Commonwealth of Kentucky
Public Employee Health Insurance Program
Second Annual Report

Prepared for:

Commonwealth of Kentucky
Governor
General Assembly
And
Chief Justice of the Supreme Court

October 1, 2002

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Executive Summary

Scope and Process

In accordance with the provisions of KRS 18A.226(5)(b), enacted by the 2000 General Assembly as a part of Senate Bill 288, this document comprises the second annual report from the Kentucky Group Health Insurance Board to the Governor, the General Assembly, and the Chief Justice of the Supreme Court. It includes:

- A review of the recommendations put forth by the Board in its October 2001 report.
- A summary of the experience of the Commonwealth's Public Employee Health Insurance Program during calendar year 2001.
- An overview of the regional cost, coverage and employee contribution variations within the Commonwealth.
- Comparisons of the Commonwealth's Public Employee Health Insurance Program to a sample of large, private sector Kentucky employers and the Commonwealth's retiree health insurance provisions to those of other state government employers.
- An overview of the Commonwealth's provider network requirements and how they have changed over time.
- An evaluation of self-funding and issues the Commonwealth should consider in determining whether to change its funding approach.
- A summary of legislated health insurance benefit mandates and mandates passed by the 2001 and 2002 General Assemblies that affect the Public Employee Health Insurance Program.

To prepare this report, research was conducted by the Office of Public Employee Health Insurance and Mercer Human Resource Consulting and presented to the Board at its monthly meetings. Based on these presentations and the Board's articulated recommendations, the report was drafted by Mercer Human Resource Consulting on behalf of the Board and modified to incorporate the Board's comments.

Please refer to the *Glossary* at the end of the report for definitions of terms used in the body of the report.

2002 Board Recommendations

Following a thorough review of the Commonwealth's Public Employee Health Insurance Program, the Kentucky Group Health Insurance Board makes the recommendations outlined in this section. Findings from the comprehensive analysis conducted by the Board, upon which these recommendations are based, are summarized in the final section of this report. Additional detail is presented in the individual sections of this report.

- Act on the following recommendations put forth by the Board in its 2001 report that are outstanding.
  - Restrict funds appropriated by the Commonwealth for employee/retiree health insurance to use for employee/retiree healthcare benefits. Therefore, consistent with KRS 18A.225(2)(g), recoup forfeitures from the healthcare flexible spending accounts funded by the Commonwealth, for those who waive health insurance, from ***all*** entities that participate in the Commonwealth Group and return these to the Commonwealth's Public Employee Health Insurance Program, to the extent permissible by federal standards.
  - To make health insurance coverage more affordable for employees' dependents, subsidize the cost of dependent health insurance premiums, to the extent financially feasible without impacting the ability to provide single coverage under the lowest cost Option A at no employee contribution.
  - Investigate pharmacy initiatives such as purchasing pools, co-pay/co-insurance structures, multiple tiers, etc. to obtain the most cost effective prescription drug benefits for the Commonwealth's Public Employee Health Insurance Program and its members.
  - Retirees of groups whose active employees do not participate in the Commonwealth's Public Employee Health Insurance Program, and their covered dependents, added about $15-$16 million in excess cost that was absorbed by the Commonwealth or other Commonwealth Group members in 2001.[1] Therefore, either:

    Require the active employees of all entities whose retirees participate in the Commonwealth's Public Employee Health Insurance Program to also participate.

    or

    Require entities whose retirees participate in the Commonwealth's Public Employee Health Insurance Program to be responsible for the actuarial difference in cost of their retirees.
  - Only self-fund the Public Employee Health Insurance Program, if it is highly likely that the risk the Commonwealth would be accepting would be offset by substantial cost savings, after taking into account not only projected claims, re-insurance premiums and third party administrator costs, but also the cost of the additional Commonwealth staff required. Also, consider the impact on the overall health insurance market in Kentucky, if the Public Employee Health Insurance Program were to self-fund, since the Commonwealth comprises approximately 20% of the individuals with insured healthcare benefits in the entire state.
  - As part of continuous quality improvement, conduct on-site reviews to validate performance results reported by the Commonwealth's Public Employee Health Insurance Program insurance carriers and/or third party administrators, including:
    - claims and eligibility audits to assess the timeliness, financial accuracy and claim coding accuracy of claims processed;

[1] *Calculated by Mercer Human Resource Consulting from data compiled by the MedStat Group as submitted by the health plans providing health insurance to the Public Employee Health Insurance Program.*

- operational reviews to evaluate staffing, systems, policies and procedures; and
- customer service assessments to determine the quality and timeliness of customer service delivered to Commonwealth Group members.

- Target benefit provisions within the Commonwealth's health insurance options to be commensurate with the market.
- Consistent with the goal of the Commonwealth's retiree health insurance program to attract and retain career employees:
  - The eligibility and state contribution provisions of the existing retiree health insurance program should be maintained for current employees and retirees.
  - For new employees, the length of service required to be eligible to participate in the retiree health insurance program should be lengthened from 5 to 10 years. However, the Commonwealth's current contribution structure should be retained for individuals in this group with ten or more years of service.
- Apply the following network requirements in determining whether health insurance bidders are qualified to offer coverage under the Public Employee Health Insurance Program in a given county:
  - Bidder must have at least one county hospital in its network, if one or more hospitals exist in the county and any bidder for that county has at least one county hospital in its network.
  - Bidder's physician network for the county must include at least 25% of the largest number of primary care physicians reported by any bidder for that county.
  - In counties where at least one bidder reports 10 or more specialists in its network, the bidder's physician network must include at least 40% of the largest number of specialist physicians reported for that county by any bidder.

Background and History

The *Health Insurance Market for Employees and Retirees of Kentucky State Government – Research Report No. 286*, dated August 12, 1999, prepared by the Program Review & Investigations Committee Staff, provides the following historical information regarding the Commonwealth's Public Employee Health Insurance Program.

> *The Commonwealth first contributed funds for the health insurance premiums of its employees in 1972. From that time until the mid 1980's, Blue Cross & Blue Shield was the only insurance carrier offered to the state group. After experimenting with two HMO plans in 1981 and 1983, the Personnel Cabinet made more than a dozen additional plans, mostly HMOs, available to employees in 1984. Still, the indemnity plan offered by Blue Cross & Blue Shield was the dominant plan chosen. Of the 90,000 employees eligible for state-provided insurance in 1987, 64,000, or 71 percent, were enrolled in the Blue Cross & Blue Shield Key Care indemnity plan.*
>
> *In September 1987, Blue Cross & Blue Shield notified state officials of its intention to cancel the Key Care plan on October 15, 1987. This led to a decision by state policymakers to self-fund the healthcare program under the name Kentucky Kare.*

As part of extensive changes to health insurance laws adopted in HB 250, the 1994 General Assembly established the Kentucky Health Purchasing Alliance (Health Purchasing Alliance), which became effective for Commonwealth Group members effective July 1, 1995. Under the Health Purchasing Alliance, from mid 1995 through 1998, Commonwealth Group members had a choice of five Kentucky Kare options. Additionally, Commonwealth Group members could also choose one of four HMO options, four POS options, or five PPO options all through several insurance carriers.

Due to mounting losses under Kentucky Kare as a result of adverse selection from diminishing enrollment, the 1998 General Assembly enacted House Bill 315, which dissolved the Health Purchasing Alliance effective December 31, 1998. This led to the Commonwealth re-establishing an independent healthcare program, the Commonwealth Public Employee Health Insurance Program, for Commonwealth Group members.

In 1999, the Public Employee Health Insurance Program offered two HMO options (A and B), two POS options (A and B) and two PPO options (A and B) through insured arrangements with seven insurance carriers (Advantage Care, Aetna, Anthem, Bluegrass Family Health, CHA Health, Humana, and Pacificare). Two indemnity plan options were offered to out-of-state retirees through Anthem. These options were continued in 2000, with the following primary revisions:

- An EPO Option C was added to provide an option to Commonwealth Group members with a lower employee premium contribution.
- Aetna was discontinued due to its elimination in the 2000 RFP process.

- A feature was added to all 2000 options that reduced the prescription drug co-payments members had to pay after they had paid 50 co-payments in a year for themselves and covered family members.
- Coverage of outpatient mental health/chemical dependency services was expanded
  - from 30 to 45 visits annually in the A options and
  - from 21 to 36 visits annually in the B options.
- Out-of-state retirees were allowed to elect any POS or PPO option offered by any of the insurance carriers insuring Commonwealth Group members, as no insurance carrier was willing to insure an indemnity plan for these individuals.
- The Commonwealth revised its contribution policy to provide a contribution that was at least equal to the Single premium rate for the lowest cost Option A in every county.

In 2001:

- The insurance carriers offering health insurance coverage to members of the Public Employee Health Insurance Program changed as follows:
  - Aetna was re-introduced as a healthcare option for the Commonwealth Group in twenty-eight counties within the Commonwealth.
  - Anthem expanded its PPO service area for Commonwealth Group members by fourteen counties.
  - Advantage Care ceased to exist.
  - Pacificare stopped offering health insurance to anyone in Kentucky.
  - Bluegrass Family Health expanded its service area for Commonwealth Group members by nine counties.
  - CHA withdrew its HMO and POS options from twenty-three counties. However it newly introduced PPO options in four eastern counties where it previously offered HMO and POS options.
  - Humana discontinued its KPPA HMO for Commonwealth Group members.
- The following changes in benefit provisions were made:
  - Prescription drug co-payments in the PPO B option were reduced. For generic drugs, the member's co-payment decreased from $15 to $10, for brand name drugs from $20 to $15 and for non-formulary drugs from $40 to $30.
  - Members' cost-sharing for diagnostic testing, in a setting other than a physician's office, was changed from 20% co-insurance after the annual deductible was met to a $10 co-payment per visit in the PPO A option.
  - Inpatient day and out-patient visit limits applicable to mental health and substance abuse services were eliminated from all of the Commonwealth Group's health insurance options, in accordance with House Bill 268, which was enacted by the 2000 General Assembly.

- Coverage of amino acid preparations and low-protein modified food products was added to all of the Commonwealth Group's health insurance options pursuant to House Bill 202, which was passed by the 2000 General Assembly.

In 2002:

- In response to requests from Legislators and members of the Commonwealth's Public Employee Health Insurance Program, the Commonwealth implemented two new requirements as a condition for a health plan to be offered in a county:
  - If one or more hospitals exists in the county and any bidder has at least one of the county's hospitals in its network, every other bidder must have at least one county hospital in its network to be qualified to be offered.
  - The health plan's network must have at least 25% of the largest number of physicians in any bidder's network for that county in order to be qualified to be offered.
- To lessen the potential impact of adverse selection, the Commonwealth stipulated that a health plan's B option premium rates must be at least 5% lower, but no more than 10% lower than the A option premium rates for the same plan type (HMO, POS or PPO) and coverage level (Single, Parent Plus, Couple, Family).
- The following changes in carrier offerings occurred:
  - Like 2001, Anthem expanded its PPO service area for Commonwealth Group members by fourteen counties.
  - Aetna was discontinued as an offering for Commonwealth Group members in eleven counties.
  - While Bluegrass Family Health's HMO and POS options were newly offered in five counties, these options were discontinued in three counties. Bluegrass Family Health's PPO option was no longer available in one county where it was available in 2001. However, this option was newly introduced in eight countries.
  - CHA's HMO and POS options were discontinued in fourteen counties and newly added in thirteen counties. Its PPO options were added in four counties, but discontinued in the four counties where offered in 2001, due to provider contracting difficulties.
  - Humana's HMO and POS options were no longer available in three counties where offered in 2001 and its PPO options were discontinued in ten counties.

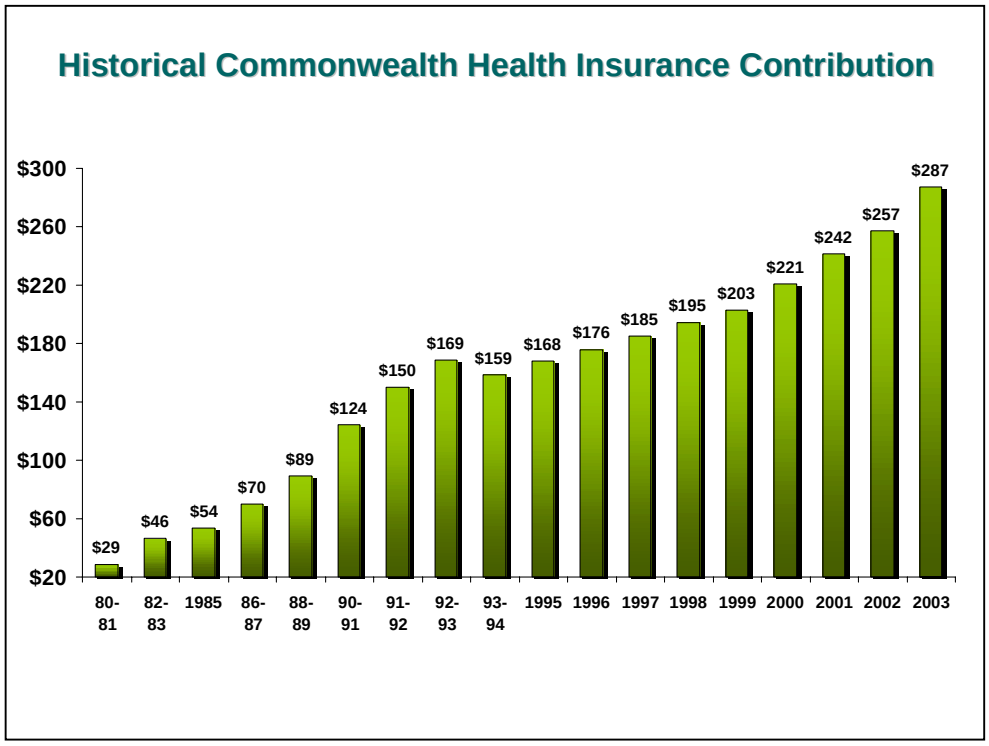
For 2003:

- Again, in response to requests from Legislators and members of the Public Employee Health Insurance Program, the Commonwealth tightened the network requirements applicable to 2003 bids:
  - The 2002 RFP hospital requirement was continued
  - However, to be qualified to be offered in a county in 2003, a health plan must:
    - have network primary care physicians of at least 25% of the largest number reported by any health plan bidding that plan type in the county and

- ♦ if any bidder has more than five specialists in a county, a health plan must have network specialist physicians of at least 40% of the largest number reported by any health plan bidding that plan type in the county.

- Aetna did not respond to the Commonwealth's RFP, as it was not willing to continue to provide health insurance to members of the Commonwealth's Public Employee Health Insurance Program. This affects eighteen counties and about 8,500 employees/retirees.
- Anthem withdrew from fifty counties, affecting around 15,600 employees and retirees.
- Bluegrass Family Health extended coverage to eight additional counties. However, due to either the Commonwealth's more stringent network requirements or termination of some providers' contracts, Bluegrass Family Health won't be an option in six counties in 2003 where it is available in 2002.
- While CHA did not extend its service area to include more Commonwealth counties in its 2003 bid, it did extend its HMO and POS options to 6 additional counties and its PPO option to 46 additional counties. However, it failed to meet the Commonwealth's 2003 network requirements in two counties where it was available in 2002.
- Humana extended coverage (PPO only) to 2 additional Western Kentucky counties for 2003. However, due to its failure to meet the Commonwealth's 2003 network requirements, Humana won't be an option in 2003 in fourteen counties where it was available in 2002.
- The following benefit revisions will become effective:
  - ➢ coverage of dental services will be limited to care required as a result of an accidental injury and anesthesia and hospital services that are medically required to safely provide dental care for children below the age of nine and persons with serious mental or physical conditions,
  - ➢ routine vision care will no longer be covered, and
  - ➢ a mail order pharmacy feature will allow members to receive a 3-month supply of maintenance prescription drugs for a 2-month co-payment.

From $9.75 per covered employee in 1972, the Commonwealth's contribution for employee health insurance has grown to an expected average of $287 in 2003. The Commonwealth's per employee contribution from the 1980-1981 plan year through 2003 is reflected in the following chart.



Source: Personnel Cabinet

2001 Board Recommendations Accomplished

The Board put forth many recommendations in its 2001 report. As indicated in the Executive Summary, the Board continues to support those 2001 recommendations that have yet to be implemented. The following briefly summarizes the 2001 recommendations that have been acted upon.

Recommendation	Resolution
Contribution Structure & Dependent Subsidies	
Pay full cost of single lowest cost Option A.	Policy still in effect.
Provide healthcare FSA to those who waive coverage at the level currently in effect.	Policy still in effect.
Provide only one healthcare contribution to each individual eligible for Commonwealth Group health insurance.	HB 846 enacted by the 2002 General Assembly tightened the "double dipping" exclusion.
Benefit Levels	
Implement mail order pharmacy feature.	HB 369 was passed by the 2002 General Assembly. Beginning January 1, 2003, members of the Public Employee Health Insurance Program will have the ability to receive a 3 month supply of a maintenance prescription drug for a 2 month co-payment via mail order.
Adverse Selection Mitigation	
Maintain the prescribed premium rate relationship between Single, Couple, Parent Plus and Family coverage levels and A and B options.	Policy still in effect.
Require all Commonwealth Group health insurers to offer a given option at the same price statewide and to allow out-of-state retirees to participate in all options with out-of-network benefits.	Policy still in effect.

Recommendation	Resolution
Restrict Commonwealth Group membership to public employees and retirees.	HB 846 enacted by the 2002 General Assembly clarifies the Commonwealth Group's eligibility definition, consistent with the Board's recommendation. It also specifies that the contribution from participating entities must be at least equal to the state's contribution rate.
Statutorily limit the ability of entities to enter and exit the Commonwealth Group.	HB 846 enacted by the 2002 General Assembly clarifies that the state-funded contribution ends, if an entity terminates participation of its active employees from the Commonwealth Group.
Do not risk adjust the premiums paid to the Commonwealth Group's insurers.	Risk adjustment has not been implemented.
Board Input	
Establish a permanent Board and include legislative and judicial representatives.	HB 163, enacted by the 2002 General Assembly, expands the Kentucky Group Health Insurance Board to include: ▪ Director of the Administrative Office of the Courts ▪ KRS retiree ▪ KTRS retiree ▪ Active teacher ▪ Active state employee ▪ Active classified education support employee HB 846, enacted by the 2002 General Assembly expands the Advisory Committee from 28 to 32 members to include: ▪ Two members from the Kentucky Association of Counties ▪ Two members from the Kentucky League of Cities The chair of this committee is a member of the Board.

Commonwealth Public Employee Health Insurance Program

This section of the report provides a summary of the trends identified from 2000 and 2001 claims and enrollment data submitted by the insurance carriers that provide health insurance coverage to individuals who participate in the Commonwealth's Public Employee Health Insurance Program, as compiled by MedStat.

Restatement of 2000 Experience

Please note that enrollment, claims and premiums for 2000 have been restated from the 2001 report to reflect:

- The actual claims incurred in 2000 that were not paid until 2001. In the 2001 report, these claims were estimated.
- Reimbursements issued by some of the Commonwealth's insurance carriers in 2001 to Commonwealth Group members who qualified for a reduction in prescription drug co-payments because they, in combination with covered family members, had more than 50 prescriptions filled in 2000 that were covered by the Commonwealth's health insurance program.
- Enrollment from the Commonwealth's eligibility database rather than the enrollment reflected in the 2001 report as reported by the Commonwealth's insurance carriers.

Reimbursements due to Commonwealth Group members who qualified for a reduction in prescription drug co-payments because they, in combination with covered family members, filled more than 50 prescriptions in 2001, are reflected in the 2001 prescription drug costs included in this report. However, claims for services and supplies received by Commonwealth Group members in 2001 that were not paid as of March 31, 2002 have been estimated to be 2% of the 2001 claims paid through March 31, 2002.

2001 Trends

Key measures for the Commonwealth's 2001 plan year, in comparison to the 2000 year, are provided in Exhibit I.

Exhibit I

	Commonwealth Group 2000 and 2001 Experience Summary		
	2000	2001	% Change
Medical Claims	$355,304,194	$400,850,186	12.8%
Rx Claims	$86,411,348	$104,421,366	20.8%
Total Claims	$441,715,543	$505,271,552	14.4%
Premiums Paid	$511,369,510	$558,002,180	9.1%
Covered Lives	225,850	225,623	(0.1%)
Per Covered Life			
Medical Claims	$131.10	$148.05	12.9%
Rx Claims	$31.88	$38.57	21.0%
Total Claims	$162.98	$186.62	14.5%
Premiums Paid	$188.68	$206.10	9.2%
Loss Ratio[2]	86.4%	90.5%	

Source: Claims and enrollment reported by the Commonwealth's insurers and compiled by OPEHI and MedStat.

In aggregate, the Commonwealth's health insurance carriers issued payments to medical providers, other than pharmacies, of roughly $401 million for services received in calendar year 2001 by Commonwealth Group members. This represents an aggregate increase of 12.8% over calendar year 2000.

Higher than marketplace trends, payments for prescription drugs in the Commonwealth's program increased by 20.8%, in aggregate, from $86.4 million in 2000 to $104.4 million in 2001. In comparison, participants in the *Mercer/Foster Higgins National Survey of Employer-sponsored Health Plans for 2001* reported aggregate prescription drug cost increases of:

- 17.8% nationally for employers in all industry groups with 500 or more employees,
- 18.2% for state government employers, and
- 17.9% for employers located in the South (U.S. census region) with 500 or more employees.

Note: The increases reported by survey respondents reflect the net increase in cost after taking into account the increases in prescription drug co-payments implemented by some survey respondents. There were no increases in members' prescription drug cost sharing in the Commonwealth's program. In fact, prescription drug co-payments in the Commonwealth's PPO B option were reduced to make them consistent with the Commonwealth's other B options.

Because prescription drug expenditures increased at a much higher rate than other healthcare expenses, pharmacy service expenditures grew as a percentage of the Commonwealth's total

[2] *Total Claims divided by Premiums Paid*

healthcare expenditures from 19.6% in 2000 to 20.7% in 2001. In 1999, prescription drugs comprised 18.1% of Commonwealth Group members' healthcare claims.

Total healthcare claims incurred in calendar year 2000 increased in aggregate by 14.4% from 2000 to 2001. In 2001, these expenditures totaled a little over $505 million. In 1999, health insurance claims totaled almost $395 million.

While claim payments to medical providers form the majority of a health plan's expenditures, every health plan, whether insured or self-insured, incurs operational expenses for claims payment, network management, care management and associated services. As the Commonwealth insured all of its health options in both calendar years 2000 and 2001, total expenditures by the Commonwealth and participating Commonwealth Group individuals to purchase health insurance are reflected in the premiums paid to the insurance carriers bearing the risk for the program. In calendar year 2001, these premium payments totaled roughly $558 million. This reflected an increase from 2000 of 9.1%. Payments for medical supplies and services received by Commonwealth Group members increased at a faster pace than premiums paid to the Commonwealth's insurance carriers. Therefore, the loss ratio (incurred claims divided by premiums) increased from 86.4% in 2000 to 90.5% in 2001. While 13.6% of premiums were retained by the Commonwealth's health insurance carriers in 2000, only 9.5% of premiums were retained by its insurance carriers in 2001 for operating expenses and profit. The 1999 loss ratio was 88.4%, 11.6% of premiums were retained by the Commonwealth's health insurance carriers in 1999.

While the figures provided above reflect changes in aggregate expenditures year over year, it is also important to consider changes in the number of covered lives. The number of employees/retirees insured under the Commonwealth's health insurance program increased 2.2% in 2001. However, due to a decline in individuals electing Family coverage (coverage for the employee/retiree, a spouse and one or more children) and to a lesser degree a decline in the Parent Plus enrollment (coverage for an employee/retiree and one or more children), the total number of covered lives insured under the Commonwealth's program remained relatively constant. Although the number of covered spouses declined slightly year over year, in essence, the increase in the number of employees/retirees covered was offset by a decline in the number of children covered. As the average claims cost for a child covered under the Commonwealth's program is roughly 36% of that of an employee/retiree, part of the Commonwealth's per capita cost increase was the result of this enrollment shift.

Medical claims, exclusive of pharmacy claims, for services and supplies received in calendar year 2001 averaged $148.05 per covered life on a monthly basis. Monthly paid claims per covered life for prescription drugs averaged $38.57 in calendar year 2001. In aggregate, the average monthly paid claims per covered life for services received in 2001 was $186.62. The average monthly premium paid by the Commonwealth and individuals insured under the Commonwealth Group health insurance program increased from $188.68 in 2000 to $206.10 in 2001.

The Commonwealth's 2001 premium increase of 9.1% is lower than the cost increase reported by employers that participated in the *Mercer/Foster Higgins National Survey of Employer-*

sponsored Health Plans for 2001. Survey respondents reported aggregate healthcare costs increases of:

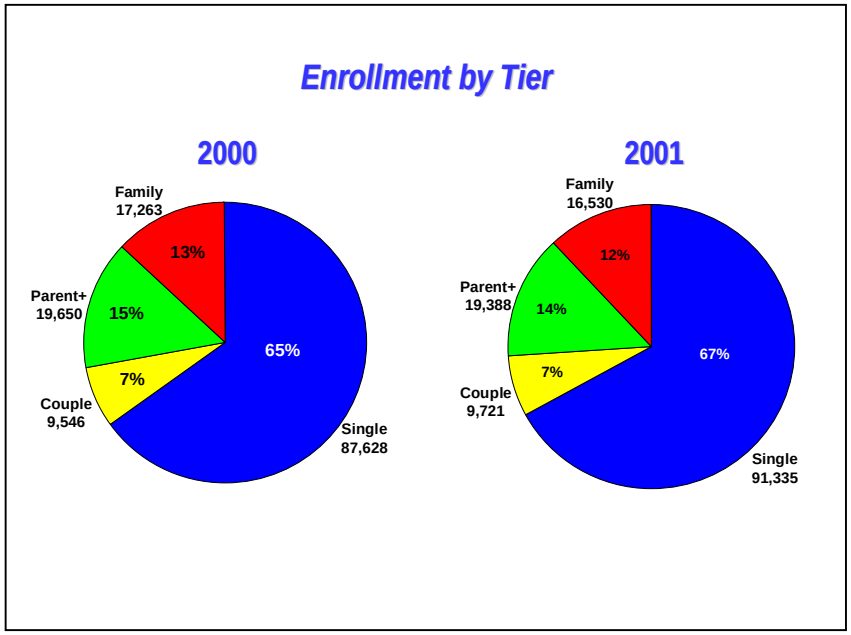
- 12.1% nationally for employers in all industry groups with 500 or more employees,
- 13.8% for state government employers, and
- 12.7% for employers located in the South (U.S. census region) with 500 or more employees.

However, payments issued by the Commonwealth's health insurance program to healthcare providers who provided medical supplies and services to members of the Commonwealth's Public Employee Health Insurance Program increased 14.4%, higher than the survey data reflected above. Additionally, the per capita increase in 2001 of 14.5% was over 2 percentage points higher than the per capita increase in 2000 of 12.4%, although the per capita prescription drug increase was slightly less in 2001 (21.0%) than 2000 (21.6%).

Enrollment Analysis

While the number of employees/retirees in the Commonwealth Group electing health insurance increased on average from 134,112 to 137,024 from 2000 to 2001, the average number of covered lives remained basically constant. As illustrated in Exhibit II below, this was the result of a decline in the number of individuals electing Family coverage. In 2000, on average, 17,263 employees/retirees elected Family coverage (coverage for a spouse and one or more children), down from 18,329 in 1999. In 2001, this decreased further to 16,530. In 2000, 19,650 employees/retirees elected Parent Plus coverage (coverage for themselves and one or more children) on average, down from 19,782 in 1999. This declined further to 19,388 in 2001. While less than the 9,888 electing Couple coverage in 1999, the number of individuals electing Couple coverage (coverage for the employee/retiree and their spouse) increased slightly from 9,546 in 2000, to 9,721 in 2001.

Exhibit II



Source: Commonwealth's enrollment reported by OPEHI and aggregated by MedStat.

The increase in covered employees/retirees coupled with the decline in individuals electing Family and Parent Plus coverage resulted in a shift in the percentage of Commonwealth Group members with Single coverage from 65% in 2000 to 67% in 2001. In 1999, the percentage with Single coverage was 64%. The continuing decline in Parent Plus and Family coverage is likely the result of two factors:

- the lack of explicit dependent subsidies in the Commonwealth's program, and
- the increasing percentage that retirees comprise of the Commonwealth Group.

Group Composition

The composition of the Commonwealth Group enrolled in health insurance changed, not only with respect to the number of dependents covered under the program, but also with respect to the key groups that comprise the Commonwealth Group. As illustrated in Exhibit III, like 1999, the number of insured individuals actively employed by state agencies, school boards, and health departments declined from 2000 to 2001. However, the number of individuals insured through KERS and KTRS increased measurably from 1999 to 2000 and from 2000 to 2001. While these two groups comprised 14.3% of the total insured Commonwealth Group in 1999, they comprised 17% of the group in 2001. As noted last year, this trend has long term cost implications for the Public Employee Health Insurance Program.

Exhibit III

	Average Covered Lives by Group 1999, 2000 and 2001							
	1999		2000		% Change	2001		% Change
	Average Lives	% of Total	Average Lives	% of Total		Average Lives	% of Total	
State Employees	61,386	27.0%	60,440	26.8%	(1.5%)	60,218	26.7%	(0.4%)
School Boards	125,188	55.2%	121,781	53.9%	(2.7%)	118,501	52.5%	(2.7%)
Health Depts.	4,562	2.0%	4,241	1.9%	(7.0%)	4,127	1.8%	(2.7%)
KERS	18,097	8.0%	20,389	9.0%	12.7%	22,313	9.9%	9.4%
KTRS	14,330	6.3%	15,368	6.8%	7.2%	16,028	7.1%	4.3%
KCTCS	2,340	1.0%	2,528	1.1%	8.0%	2,968	1.3%	17.4%
COBRA	1,045	0.5%	1,104	0.5%	5.6%	1,466	0.6%	32.8%
Total	226,948		225,851			225,621		(0.1%)

Source: Commonwealth's enrollment aggregated by MedStat.

As happened from 1999 to 2000, the number of Kentucky Community and Technical College System (KCTCS) insured individuals increased significantly from 2000 to 2001. When KCTCS was formed as an entity separate from the University of Kentucky, individuals in this group were given the option of remaining in the UK benefits package or joining the Commonwealth Group. Individuals hired after this separation have only been eligible to join the Commonwealth's health insurance program.

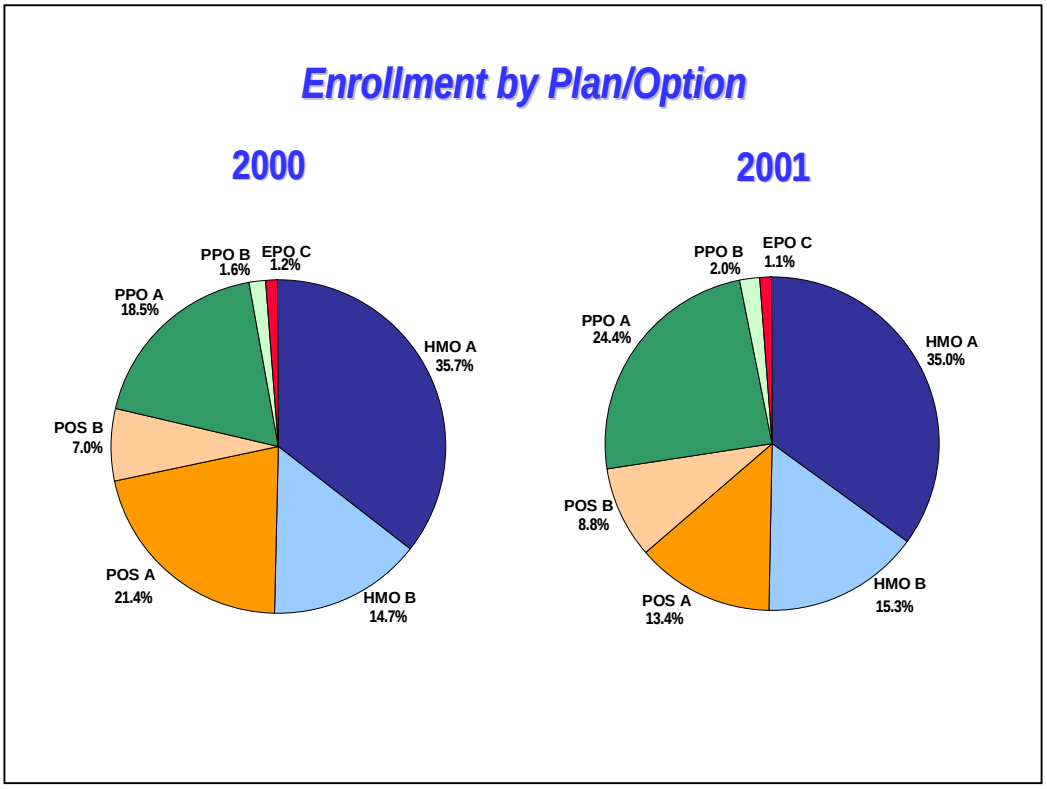
The number of individuals electing COBRA coverage increased significantly (almost 33%) in 2001, from around 1,104 individuals in 2000 to 1,466 in 2001. These represent individuals who

lost eligibility for healthcare coverage through the Commonwealth Group who, through federal statute, are eligible to continue their healthcare coverage for a period of time under the Commonwealth's healthcare program. As the average claims cost for COBRA individuals is higher than that of the Commonwealth Group overall, it is fortunate that while the percentage increase in enrollment was significant, there are still relatively few COBRA participants.

Enrollment by Option

The Commonwealth Group's enrollment by plan and option in 2000 and 2001 is illustrated below.

Exhibit IV



Source: Commonwealth's enrollment aggregated by MedStat.

In aggregate, HMO enrollment remained relatively constant from 2000 to 2001. However, the percentage enrolled in the HMO A option dropped slightly from 35.7% to 35%, while HMO B experienced a corresponding increase from 14.7% to 15.3%. Point of Service (POS) enrollment declined dramatically from 2000 to 2001 from 28% to 22%. A similar drop occurred from 1999 to 2000. As the POS options are the most expensive options that the Commonwealth offers in areas where a choice of plan types is available, it is likely that premium cost increases were a factor in the POS enrollment decline.

The decline in POS enrollment was offset by an increase in Preferred Provider Organization (PPO) Option A enrollment, which grew from 18.5% in 2000, to 24.4% in 2001. There was only

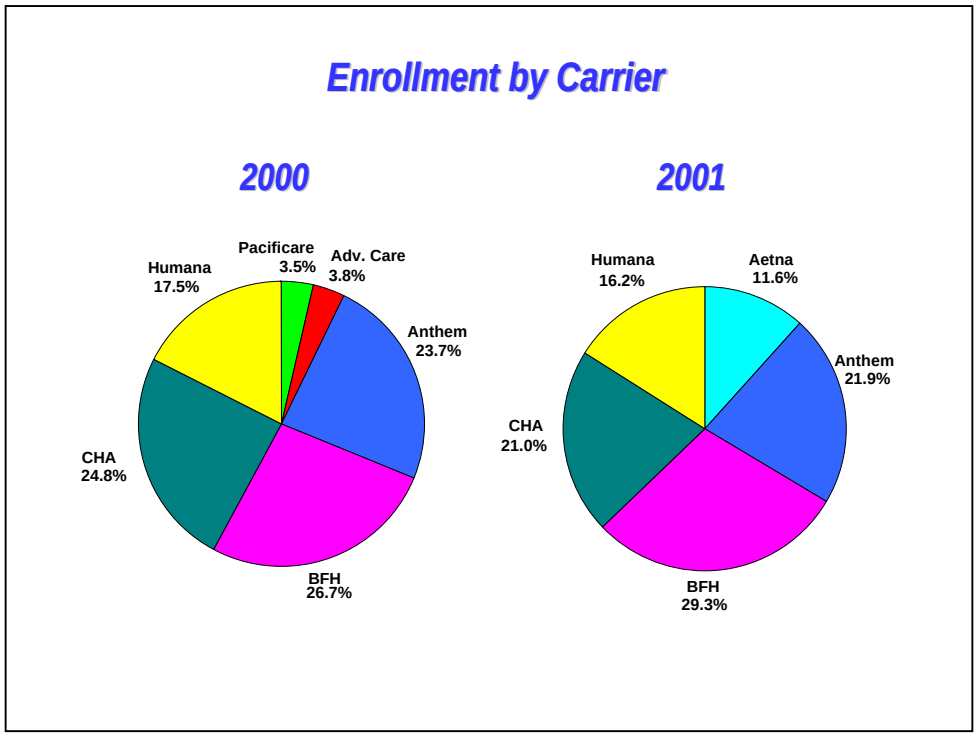
a slight increase from 1.6% to 2%, in the PPO Option B. Enrollment in the EPO plan, first introduced in 2000, remained virtually constant from 2000 to 2001.

Overall, there was a shift from the higher priced options, A options and POS options, to the lower cost B and PPO options.

Enrollment by Insurer

The charts in Exhibit V below contrast the percentage of Commonwealth Group members enrolled in each carrier's offerings in 2000 and 2001. The primary change in enrollment by insurance carrier from 2000 to 2001 resulted from the return of Aetna as an offering in 2001 and the exit of Pacificare and Advantage Care from the Kentucky insurance market.

Exhibit V



Source: Commonwealth's enrollment aggregated by MedStat

Of the carriers who offered coverage in both 2000 and 2001, only Bluegrass Family Health's (BFH) enrollment percentage increased in 2001. This was due to:

- an increase in the number of counties in which Bluegrass Family Health was offered from 58 in 2000 to 67 in 2001,
- a decline in the number of counties in which CHA was offered, and
- the demise of Advantage Care.

In 2001, CHA was offered in 59 counties, down from 78 in 2000. This was the primary cause of the decrease in CHA's enrollment percentage from roughly 25% in 2000 to 21% in 2001. Additionally, with an HMO A single premium rate that was $38.54 less per month than CHA's, Aetna's re-entrance created more competition for CHA in Northern Kentucky.

Both Anthem and Humana increased the number of counties in which they were offered in 2001. However, this did not result in an increase in either carrier's enrollment percentage in 2001. In fact, both lost enrollment in 2001, primarily due to the return of Aetna in 2001. Aetna's single HMO Option A rate was only one dollar more than the Commonwealth's contribution in the counties in which Aetna was offered. For only one dollar, individuals could purchase the single HMO Option A through Aetna rather than receiving the Single PPO Option A at no cost. Also, the Aetna rate for HMO A Single coverage was $45.48 less monthly than Anthem's and $14.68 less than Humana's.

Prescription Drug Experience

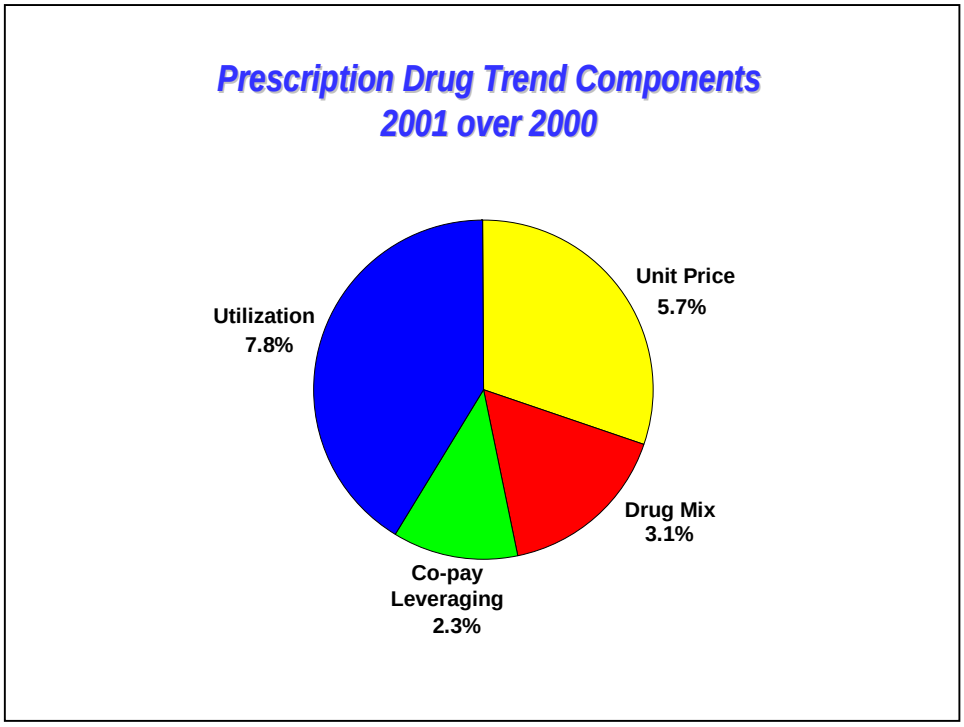
Consistent with marketplace trends, increases in prescription drug expenditures under the Commonwealth Group health insurance program out paced cost increases for other covered services. This increase is attributable to four identifiable factors:

- an increase in unit price per prescription for the same drug (*Unit Price*),
- a change in the mix of drugs received by Commonwealth Group members (*Drug Mix*),
- co-payment leveraging – the impact of fixed dollar co-payments on the Commonwealth's health plan's cost in relation to unit price increases (*Co-pay Leveraging*), and
- an increase in the number of prescriptions received by Commonwealth Group members (*Utilization*).

Unit Price

As illustrated in Exhibit VI, unit price, as measured by comparing the price per prescription for all drugs utilized by Commonwealth Group health members, increased 5.7% from 2000 to 2001. This component of the Commonwealth's prescription drug expenditure increase is limited to the pure price increase that would have resulted if covered individuals received exactly the same drugs in 2000 as were received in 2001. The increase in unit drug prices in 2001 of 5.7% was higher than the increase in 1999 of 4.1%.

Exhibit VI



Source: Claims and enrollment reported by the Commonwealth's insurers, compiled by OPEHI and MedStat, and analyzed by Mercer.

Drug Mix

Over time, physicians' prescribing patterns and patients' preferences for certain prescription drugs change. This has been dramatically affected by three factors:

1) "direct-to-consumer" advertising by the pharmaceutical industry,
2) increases in the number of pharmaceutical representatives who call on physicians, and
3) an influx of new drugs into the marketplace.

To measure the impact that changes in the mix of prescriptions that Commonwealth Group health members received had on the Commonwealth's health plan's pharmacy costs, the average

cost per prescription for 2000 was compared to 2001. After eliminating the change in pharmacy costs due to pure price increases (5.7%), the resulting increase in the cost per prescription from 2000 to 2001 due to the change in the mix of drugs received was 3.1%. (In 1999, the increase in prescription drug cost due to drug mix was 3.5%).

Co-Pay Leveraging

When prescriptions are received from a network pharmacy, Commonwealth Group members pay a fixed dollar co-payment for each prescription. These co-payments have remained the same or declined since 1999. Due to the fact that the amount that Commonwealth Group members paid for prescriptions remained constant or declined while the cost per prescription increased, the amount paid by the Commonwealth's health plan, per prescription, increased in 2001 at a higher rate than the total cost per prescription. In 2001, the leveraging resulting from the fixed dollar prescription drug co-payments in the Commonwealth's health insurance program resulted in an increase in prescription drug costs of 2.3%. (In 1999, the increase in prescription drug costs due to co-pay leveraging was 2.4%.)

Prescription Drug Utilization

The final component of the Commonwealth Group's prescription drug expenditure increase from 2000 to 2001 was due to an increase in the number of prescriptions that were received by Commonwealth Group members. The number of prescriptions covered by the Commonwealth's health plan increased 7.8% from 2000 to 2001. The corresponding utilization increase in 2000 was 6.8%.

Detailed prescription drug utilization data was not available from Advantage Care and Pacificare for the Commonwealth's 2000 plan year due to these carriers' financial difficulties. However, an analysis of prescription utilization information for the remaining Commonwealth carriers indicates that the number of prescriptions per covered individual increased from 14.9 to 16.1 from 2000 to 2001, an increase of 7.8%. Based on the available per member per month utilization data available for 2000 and 2001:

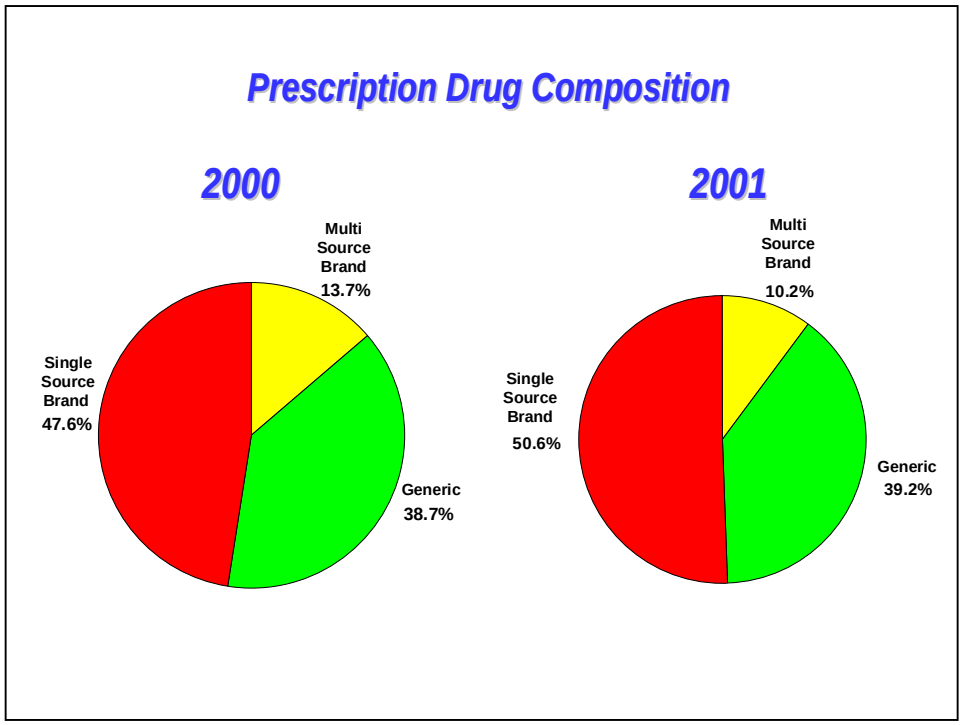
- The number of single-source brand name drugs received by Commonwealth Group members increased at the fastest pace, 14.5%.
- The number of multi-source brand prescriptions, those drugs for which an alternative generic drug is available, decreased 19.7%.
- Generic prescriptions, the least expensive type of prescription, increased, but at a much lower rate, 9.1%, than single-source brand drugs, which have a much higher cost.

In essence, the majority of the increase in prescriptions was likely a result of changes in physician prescribing patterns, new drugs entering the marketplace, and patients' preferences, perhaps fueled by direct-to-consumer advertising.

As illustrated in Exhibit VII, due to the unequal increase in utilization by type of prescription, the percentage of prescriptions received by Commonwealth Group members dispensed as single source brand name drugs grew from 47.6% to 50.6% in 2001. Multi-source brand name drugs

declined from 13.7% of prescriptions received to 10.2%. The generic prescription percentage increased from 38.7% to 39.2%.

Exhibit VII



Source: Claims and enrollment reported by the Commonwealth's insurers, compiled by OPEHI and MedStat, and analyzed by Mercer.

Findings

Key trends for the 2001 plan year, in comparison to 2000, are:

- The Commonwealth's 2001 premium increase of 9.1% is lower than the cost increase reported by employers that participated in the *Mercer/Foster Higgins National Survey of Employer-Sponsored Health Plans for 2001*. Survey respondents reported aggregate healthcare costs increases of:
  - 12.1% nationally for employers in all industry groups with 500 or more employees,
  - 13.8% for state government employers, and
  - 12.7% for employers located in the South (U.S. census region) with 500 or more employees.

  However, fueled by increases in prescription drug expenditures of 20.8%, aggregate payments issued to healthcare providers who provided medical supplies and services to members of the Commonwealth's Public Employee Health Insurance Program increased 14.4%, a faster pace than experienced by respondents to Mercer's survey.
- As payments for the medical supplies and services received by Commonwealth Group members increased at a faster pace than premiums paid to the Commonwealth's health

insurance carriers, the plan's overall loss ratio increased from 86.4% in 2000 to 90.5% in 2001. In 2001, a greater share of the Commonwealth's and Commonwealth Group members' premium payments went to pay healthcare providers than in 2000, leaving a smaller percentage of premium dollars to pay the insurers' operating expenses and contribute to their profits.

- While the number of employees and retirees insured under the Commonwealth's health insurance program increased 2.2% in 2001, due to a decline in the number of individuals electing dependent healthcare coverage, the number of covered lives remained virtually the same as in 2000.
- The number of active employees, excluding covered dependents, insured under the Commonwealth's health insurance program increased, on average, by roughly 700 individuals from 2000 to 2001. However, the number of covered retirees, excluding covered dependents, increased, on average, by almost 2,000. Retirees and their covered dependents comprised 14.3% of the total insured Commonwealth Group in 1999. This grew to 17.0% in 2001. This trend has long-term cost implications for the Public Employee Health Insurance Program.
- HMO enrollment remained relatively steady at around 50% of the group, although there was a slight decline in the percentage of Commonwealth Group members enrolled in HMO A (about 7/10ths of one percent) with a corresponding increase in HMO B enrollment. Point of Service (POS) enrollment continues to decline dramatically, from 33% in 1999 to 28% in 2000 and 22% in 2001. This decline was offset by increases in Preferred Provider Organization (PPO) enrollment. PPO enrollment grew from roughly 20% in 2000 to over 26% in 2001, with the majority of this increase occurring in PPO option A in which enrollment grew from 18.5% to 24.4%. Enrollment in the Exclusive Provider Option implemented by the Commonwealth January 1, 2000 declined slightly, less than 100 employees/retirees.
- The primary change in enrollment by insurance carrier from 2000 to 2001 resulted from the re-entrance of Aetna as an offering in 2001. Around 12% of Commonwealth employees/retirees migrated to Aetna in 2001. Additionally, enrollment in Bluegrass Family Health increased from about 27% in 2000 to a little over 29% in 2001, due to Blue Grass Family Health's expansion into nine additional counties of the Commonwealth coupled with the withdrawal of CHA from 19 counties. Enrollment declines for the other carriers offering coverage to Commonwealth Group members were are follows:
  - Anthem declined from roughly 24% in 2000 to 22% in 2001,
  - CHA declined from about 25% to 21%, and
  - Humana declined from 17.5% to about 16%.
- The 2001 per capita increase in prescription drug expenditures in the Public Employee Health Insurance Program of 20.8% was higher than reported by participants in the *Mercer/Foster Higgins National Survey of Employer-Sponsored Health Plans for 2001*. Survey respondents reported aggregate prescription drug costs increases of:
  - 17.8% nationally for employers in all industry groups with 500 or more employees,
  - 18.2% for state government employers, and

- 17.9% for employers located in the South (U.S. census region) with 500 or more employees.

Note: The increases reported by survey respondents reflect the net increase in cost after taking into account the increases in prescription drug co-payments implemented by some survey respondents.

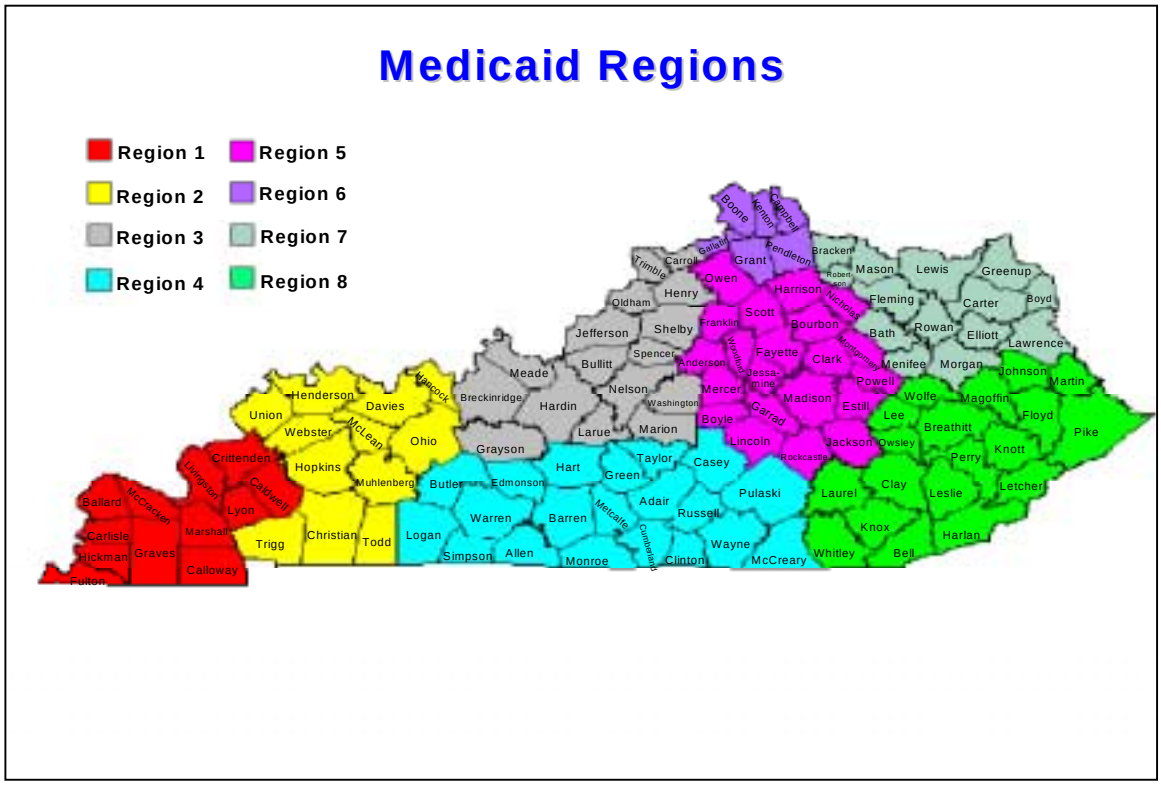
Although the Commonwealth improved the prescription drug benefit in its PPO B option in 2001, enrollment in this option is only 2% of the total group. Therefore, this change had a negligible impact on the Commonwealth's 2001 prescription drug costs. Based on data reported by the Commonwealth's insurance carriers and aggregated by MedStat, the increase is attributable to four quantifiable factors:

- an increase in unit price per prescription for the same drug – accounted for a 5.7% increase in prescription drug costs,
- a change in the mix of drugs received by Commonwealth Group members – accounted for a 3.1% increase in prescription drug costs,
- co-payment leveraging, the impact of fixed dollar co-payments on the Commonwealth's health plan's cost in relation to unit price increases – which accounted for an increase of 2.3%, and
- utilization – an increase of 7.8%.

Regional Variations within the Commonwealth

Due to regional differences in the health care costs of Commonwealth Group members and/or the ability of insurance carriers to obtain contracts with providers in certain areas of the state, the health plan choices and employee contributions for dependent health insurance coverage currently vary across the state. To begin to determine the reasons for these differences, the Board requested that Mercer Human Resource Consulting analyze health insurance costs of Commonwealth Group members in various areas of the Commonwealth. For this analysis, Mercer relied upon the Medicaid regions previously established by the Commonwealth, based on the Commonwealth's analysis of where Commonwealth residents receive their healthcare services. These regions are illustrated in the chart in Exhibit VIII.

Exhibit VIII



The analysis of average monthly allowed charges for the healthcare services received by Commonwealth Group members in 2001 provided in Exhibit IX illustrates the variation in the cost of health care services consumed by Commonwealth Group members in different regions of the Commonwealth.

Note: Allowed charges are the amounts charged by healthcare providers (physicians, hospitals, pharmacies, therapists, etc.) for the services, supplies and prescription drugs received by Commonwealth Group members after application of the health plan's negotiated discounts, but prior to any member deductibles, co-payments, or co-insurance.

Exhibit IX

	2001 Average Monthly Allowed Charges Per Commonwealth Group Member				
	Employees/Retirees Only		Employees, Retirees and Covered Dependents		
	Average Per Person	Relation to Group Overall	Average Per Person	Relation to Group Overall	Demographic Factor
Out of State	$498	183%	$393	172%	124%
Region 1	$286	105%	$238	104%	103%
Region 2	$287	105%	$244	107%	102%
Region 3	$278	102%	$230	101%	102%
Region 4	$252	93%	$211	92%	100%
Region 5	$267	98%	$219	96%	98%
Region 6	$253	93%	$210	92%	101%
Region 7	$279	103%	$232	102%	99%
Region 8	$255	94%	$217	95%	96%
Total Group	$272		$228		

Source: Mercer analysis based on data compiled by MedStat from the Commonwealth's health insurance carriers and OPEHI.

The figures in each of the columns of Exhibit IX are as follows:

- Average Per Person under "Employees/Retirees Only" – reflects the total cost of healthcare services consumed in 2001 by Commonwealth Group employees and retirees who elected coverage in the identified region, divided by the number of Commonwealth Group employees and retirees in that region, divided by 12.
- Relation to Group Overall under "Employees/Retirees Only" – shows how the average employee/retiree cost in each region compares to the average cost of all employees/retirees covered under the Public Employee Health Insurance Program. The percentages in this column were derived by dividing the Average Per Person for each region by the Average Per Person for the Commonwealth Group overall.
- Average Per Person under "Employees, Retirees and Covered Dependents" – reflects the total cost of healthcare services consumed in 2001 by Commonwealth Group employees, retirees and their covered dependents who elected coverage in the identified region, divided by the number of Commonwealth Group employees, retirees and covered dependents in that region, divided by 12.
- Relation to Group Overall under "Employees, Retirees and Covered Dependents" – shows how the average cost in each region for all individuals in that region compares to the average

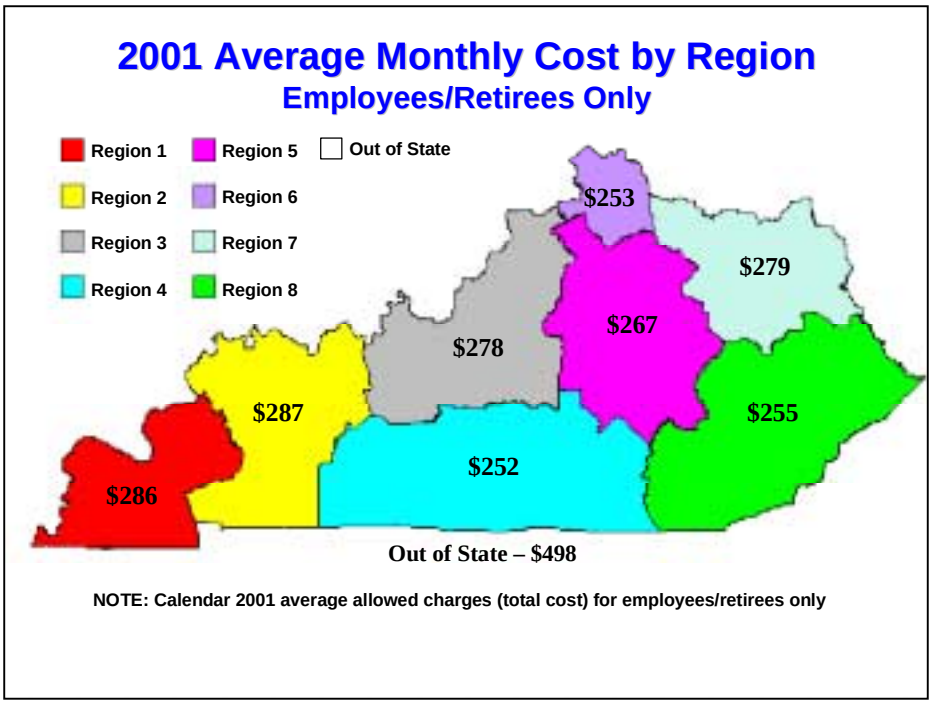
cost for all individuals covered under the Public Employee Health Insurance Program. The percentages in this column were derived by dividing the Average Per Person for each region by the Average Per Person for the Commonwealth Group overall.

- Demographic Factor under "Employees, Retirees and Covered Dependents" – illustrates how the average cost for each region would be expected to compare to the average cost for the Commonwealth Group in total based on the age and gender of the employees, retirees and covered dependents electing coverage in that region. The demographic factors were derived as follows:
  - The 2001 allowed charges for the entire Commonwealth Group were determined separately for males and females by age brackets: <1, 1-4, 5-9, 10-14, 15-17, 18-19, 20-24, 25-29, 30-34, 35-39, 40-44, 45-49, 50-54, 55-59, 60-64, 65-74, 75-84, 85+.
  - The total 2001 allowed charges for each gender/age bracket were divided by the number of total Commonwealth Group members in that gender/age bracket to determine the average 2001 allowed charges per member for each gender/age bracket.
  - The average 2001 allowed charges per member for each gender/age bracket for the Commonwealth Group overall were multiplied by the number of individuals in each region in that gender/age bracket to get the demographically expected cost for that gender/age bracket.
  - The "demographically expected cost" for each gender/age bracket for a given region were summed to obtain the total "demographically expected cost" for that region based on the Commonwealth Group's overall experience and the demographics of the covered population in that region. This total "demographically expected cost" was divided by the number of covered individuals in the region to obtain the average demographically expected cost per member for the region.
  - The average demographically expected cost per member for each region was divided by the average cost per individual for the Commonwealth overall to arrive at the Demographic Factor for the region.

Not surprisingly, the 2001 average allowed charges for employees/retirees residing outside the Commonwealth were higher than any region within the Commonwealth, since this group is comprised predominately of retirees. However, the average monthly allowed charges for these individuals and their covered dependents were 72% higher than the average for the entire Commonwealth Group while their demographics only indicate that their costs should be 24% higher than the group overall. The demographic factors for Regions 1, 3, 5 and 8 track the actual experience in these regions fairly closely. However, the variance between the demographic factor and actual experience for Regions 2, 4, 6 and 7 indicates that factors other than demographics – the health status of individuals in that region, the cost per service charged by the providers used by individuals in that region, provider practice patterns, or access to health care providers – is affecting health insurance costs. As additional data becomes available, OPEHI will seek to ascertain the factors that are causing regional costs to differ.

The 2001 average costs for employees/retirees are illustrated another way in the chart in Exhibit X.

Exhibit X



Source: Mercer analysis based on data compiled by MedStat from the Commonwealth insurance carriers and OPEHI.

Even within some regions, the Commonwealth's 2001 average monthly allowed charges varied significantly from one county to another. This is reflected in the table in Exhibit XI, for counties with at least 950 employees/retirees.

Exhibit XI

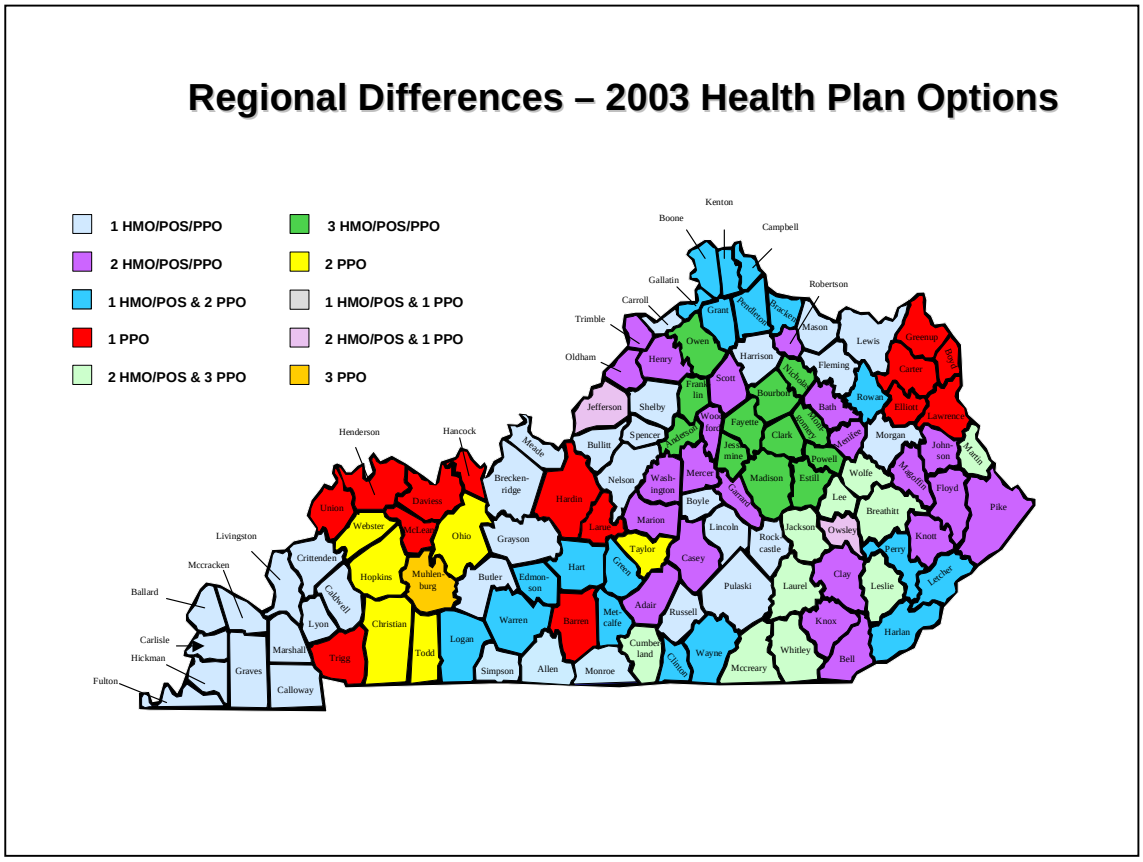
	Variations within Regions in 2001 Average Monthly Allowed Charges for Employees/Retirees Only within Regions		
	Lowest Cost County	Highest Cost County	Variation
Region 1	$280	$306	9%
Region 2	$262	$304	16%
Region 3	$274	$292	7%
Region 4	$233	$263	13%
Region 5	$229	$305	33%
Region 6	$240	$263	10%
Region 7	$245	$365	49%
Region 8	$210	$323	54%

Source: Mercer analysis based on data compiled by MedStat from the Commonwealth's health insurance carriers and OPEHI.

NOTE: Only counties with 950 or more employees/retirees were included in the analysis shown in Exhibit XI.

At least partially influenced by the variation in cost among regions and even counties within the Commonwealth, the health insurance options and employee contribution amounts in the Commonwealth's health insurance program vary by region. Employees' 2003 health insurance choices are reflected in Exhibit XII.

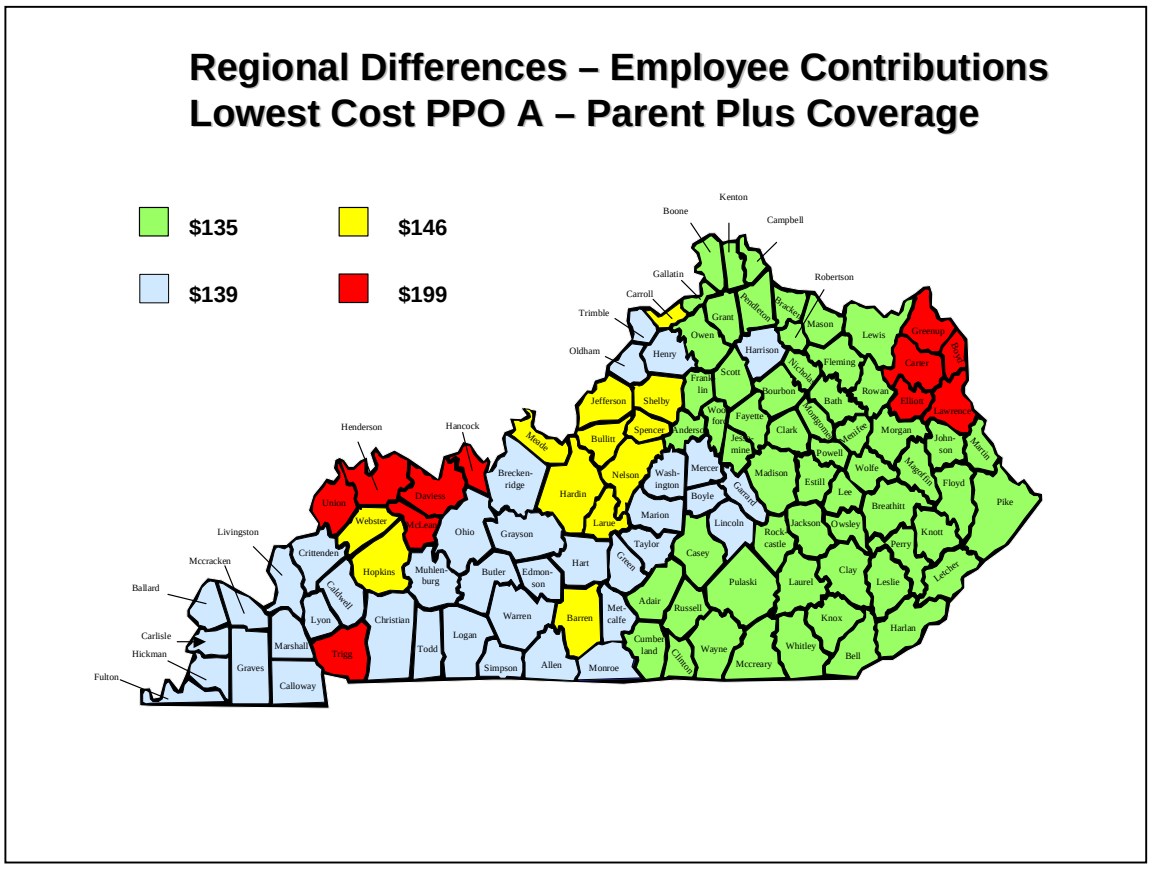
Exhibit XII



Source: Mercer from the Commonwealth's 2003 open enrollment materials.

While the Commonwealth pays 100% of the single premium cost for the lowest cost Option A in every county, the Commonwealth does not explicitly subsidize the premium cost of dependent health insurance coverage for its employees/retirees. Therefore, as the health insurers available to Commonwealth Group members vary by county, employees' health insurance contributions for dependent health insurance vary also. The variation in employee contributions for Parent Plus coverage under the lowest cost option A in 2003 is illustrated in Exhibit XIII.

Exhibit XIII



Source: Mercer from the Commonwealth's 2003 open enrollment materials.

Under its current funding arrangement, it is extremely difficult for the Commonwealth to offer the same health plan choices at the same cost in every county of the Commonwealth. While this goal could be achieved if the Commonwealth self-funded its program, it would result in fewer carrier choices in some counties and higher costs in some counties. Additional information is provided in the Self-Funding section.

Market Comparison

The October 2001 Board report included a comprehensive comparison of the Commonwealth's Public Employee Health Insurance Program to that of other states. This year, the information from the Commonwealth's 2001 survey of other states is supplemented by:

- Results from an internet and telephone survey of other states regarding their eligibility requirements for retiree health insurance and retiree health insurance contribution structure,
- Information about the health insurance benefits of a sample of large, private sector Kentucky employers, and
- An illustration of how the Commonwealth allocates its health insurance funding among employees and retirees who are eligible to participate in the Public Employee Health Insurance Program.

Retiree Health Insurance Benefits of Other State Governments

At the request of the Board, Mercer Human Resource Consulting conducted an internet search in September, 2002 to obtain information about the retiree health insurance programs of other states. Where possible, for states that border Kentucky, Mercer confirmed or supplemented the information available from the internet through a telephone survey. A list of the twenty-seven states for which information is included in the survey results is provided in Appendix A along with the source of the data used for each state.

Retiree Health Insurance Eligibility Requirements of State Government Employers

There are many variations in states' eligibility requirements for retiree health insurance. And, it is not uncommon for states to have:

- Multiple ways that an individual can qualify to participate in the retiree health insurance program – for example, in one state, the individual must have at least ten years of service with the state and be age 62 or older on the date of employment termination or the individual's age plus service must total 80 or more.
- More stringent eligibility requirements to receive a state contribution for retiree health insurance than to participate in the program.

The table in Exhibit XIV shows the least amount of state service and youngest age required to participate in the retiree health insurance programs of the twenty-six states for which this information was available.

Exhibit XIV

Pre-65 Retiree Health Insurance Eligibility Requirements of Other State Governments	
Minimum Requirement (Service/Age)	**Percentage of States with This Requirement**
No age or years requirement	3.85%
5 years / Any age	3.85%
5 years / Age 55	15.38%
5 years / Age 60	7.69%
5 years / Age 62	3.85%
8 years / Age 60	3.85%
8 years / Any age	3.85%
10 years / Any age	3.85%
10 years / Age 55	19.23%
10 years / Age 60	15.38%
10 years / Age 62	3.85%
20 years / Age 55	3.85%
20 years / Age 62	3.85%
30 years / Any age	3.85%
Age + years of service = 80 or more	3.85%

Source: Internet and telephone survey conducted by Mercer Human Resource Consulting in September 2002

Overall, 35% of the states require 5 years of service or less to participate in their pre-65 retiree health insurance program. However, not all of these states contribute toward the cost of retiree health insurance coverage, particularly for retirees with only 5 years of service. Forty-two percent of states require ten years of state service to be eligible to participate in their retiree health insurance program and 58% require ten or more years of service for retiree health insurance eligibility.

Currently, the Commonwealth of Kentucky's retiree health insurance eligibility requirements are more liberal than the majority of the states reflected in the above results. The Commonwealth only requires 5 years of service to be eligible to participate in its retiree health insurance program, and it contributes 25% of the cost of Single coverage at 5 years of service.

State Contributions to Retiree Health Insurance

Like eligibility requirements, there are many variations in the retiree health insurance contribution policies of states. For example, one state's materials indicate that it establishes a bank for individuals when they retire, with the balance in the bank equal to the value of 50% of the individual's unused sick leave balance. The retiree can then draw from this account to pay his/her retiree health insurance premiums, until the bank is depleted. Another state requires retirees with less than 15 years of service to pay the full cost of their health insurance. However, for those retirees with 15 or more years of service, the state contributes $4 per month for each year of state service toward the cost of retiree health insurance. To simplify the comparison of the Commonwealth's retiree health insurance contribution structure with that of other states, the table in Exhibit XV summarizes pre-65 retiree health insurance contributions for retirees with 20 years of state service for the twenty-seven states for which this information was available.

Exhibit XV

	Pre-65 Retiree Health Insurance Contribution Policies of Other State Governments	
	Retiree Premium	Dependent Portion of Premium
No State Contribution	9	12
State and Retiree Share in Premium Cost	8	7
State Pays Full Premium	10	8
Average % Paid by State	56%	45%
Average Monthly Retiree Contribution	$125	$296 *(couple coverage)*

Source: Internet and telephone survey conducted by Mercer Human Resource Consulting in September 2002.

In comparison, at twenty years of service, the Commonwealth of Kentucky pays the full premium cost for Single coverage under the lowest cost Option A plan for pre-65 retirees. Like active employees, the Commonwealth does not contribute toward the cost of dependent health insurance coverage for retirees, except for hazardous duty employees.

Health Insurance Benefits of Large, Private Sector Kentucky Employers

Although not a statistically valid sample, Mercer compiled information from ten large, private sector, Kentucky employers' health insurance programs (2001 and 2002 data) for comparison to the Commonwealth's program. These include: 4 manufacturers, 3 healthcare systems, 1 utility, 1 grocery chain and 1 quick service restaurant employer (salaried employees only). The results of this compilation are reflected in Exhibit XVI.

Exhibit XVI

	Comparison of Large Private Sector Kentucky Employers' Health Insurance Plans to the Commonwealth's Program			
	HMO		PPO In-Network	
	Large KY Employers	Commonwealth of KY*	Large KY Employers	Commonwealth of KY*
Hospital inpatient	$100 or 0%	$100	10%	20%
Outpatient hospital	$0	$50	10%	20%
Physician office	$10	$10	$10	$10
Rx – retail				
Generic	$7	$10	$7	$10
Brand	$15	$15	$14	$15
Non Formulary	$25	$30	$24	$30
Annual deductible	N/A	N/A	$200	$250
Annual out-of-pocket max	Unlimited	$1,000	$1,000	$1,250
Employee Contributions	*Average*	*Weighted Average*	*Average*	*Weighted Average*
Employee	$ 51	$ 38	$ 36	$ 4
Parent Plus	$122	$184	$ 95	$140
Couple	$142	$402	$104	$344
Family	$189	$475	$145	$406

* 2002 Option A

Source: Mercer Human Resource Consulting, Inc.

While the health plan provisions of large, private sector Kentucky employers are similar to those of the Commonwealth's program, the Commonwealth's contribution structure differs significantly from these employers.

- The Commonwealth pays the full cost of Single coverage under the lowest cost Option A available. Only 10% of the large, private sector Kentucky employers in the Mercer sample pay the full cost of Single health insurance coverage for their employees.
- The Commonwealth does not explicitly subsidize the cost of dependent health insurance coverage. All of the large, private sector Kentucky employers in the Mercer sample subsidize the cost of dependent health insurance coverage for their employees. This subsidy averages 70% of the dependent portion of the health insurance premium.
- The Commonwealth contributes $234 each month to a healthcare flexible spending account for those employees who waive health insurance through the Public Employee Health Insurance Program. Only 25% of large, private sector Kentucky employers in the Mercer sample offer an alternative benefit to individuals who waive health insurance. Of those that provide an alternative benefit, the benefit is $50 or $75 per month.

Other key points regarding the health insurance programs of large, private sector Kentucky employers in the Mercer sample include:

- Eighty percent self-fund all of their health insurance options.
- 67% offer coverage to pre-65 retirees.
- For four employers for which data was available, retirees pay higher health insurance premium contributions than active employees:
  - For PPO coverage, retirees contribute from $35 to $294 monthly for retiree only coverage.
  - For HMO coverage, retirees contribute from $57 to $356 monthly for retiree only coverage.

Allocation of Commonwealth's Health Insurance Funding

In some respects, the Commonwealth's health insurance program is more generous than the typical program of other states:

- The Commonwealth provides a $234 monthly contribution to a healthcare flexible spending account for eligible employees who waive health insurance through the Public Employee Health Insurance Program. In comparison only four of thirty-six states in the Commonwealth's 2001 survey provided an alternative benefit to individuals who waive health insurance. The alternative benefits reported include: a $25 monthly flexible spending account contribution, a $108 monthly cash option and a $128 flex credit.
- The Commonwealth pays the full cost of Single coverage under the lowest cost Option A for employees and retirees with 20 or more years of service. Only 38% of other states in the Commonwealth's 2001 survey reported that they paid the full cost of employee only health insurance premiums.
- The Commonwealth has more liberal retiree health insurance provisions.

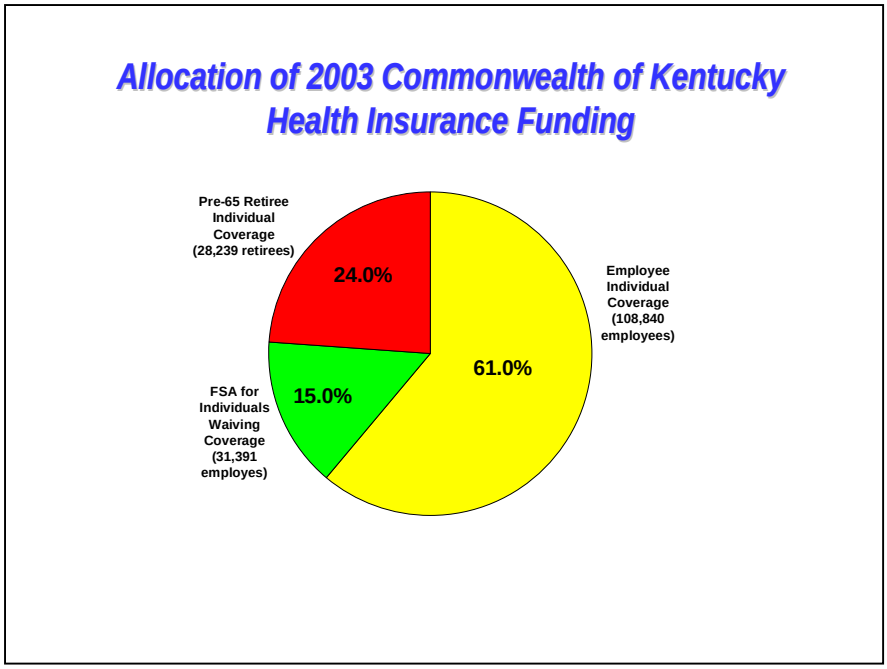
These differences are very similar to those between the Commonwealth's program and large, private sector Kentucky employers.

Other aspects of the Commonwealth's program are less generous than other states' and large, private sector Kentucky employers programs, most notably, the lack of explicit dependent subsidies in the Commonwealth's program.

In essence, the Commonwealth has chosen to allocate its health insurance funding in a different manner than the typical state or large, private sector Kentucky employer. The chart in Exhibit XVII, illustrates how the Commonwealth allocates its health insurance funding.

When comparing an employer's health insurance benefits to the market, it is important to review all aspects of the program to draw an appropriate comparison.

Exhibit XVII



Source: Mercer Human Resource Consulting from 2001 Commonwealth state survey and the Commonwealth's 2003 health insurance bids.

NOTE: The allocation of the Commonwealth's contribution for individual coverage between employees and retirees in Exhibit XVII, reflects the relationship between the average healthcare cost of active employees in the Commonwealth's program and that of retirees. Based on 2001 healthcare costs, the average cost for a retiree was 1.56 times that of an active employee.

In calendar year 2003, it is estimated that the Commonwealth will expend $588 million on health insurance for employees and pre-65 retirees.

- $366 million for employee individual health insurance coverage,
- $144 million for retiree individual health insurance coverage, and
- $88 million for employees and retirees who waive health insurance through the Commonwealth.

The Commonwealth's Provider Network Requirements

In procuring health insurance for members of the Public Employee Health Insurance Program for plan years 1999, 2000 and 2001, the Commonwealth relied upon the Department of Insurance's provider network standards. These standards are:

- In urban areas: Network providers must be available to all persons enrolled in the plan within 30 miles or 30 minutes of each individual's residence or work site, to the extent services are available.
- In other areas: Network primary care physician, hospital, and pharmacy services must be available within 30 miles or 30 minutes of each enrollee's residence or work site, to the extent services are available. Other providers must be available in the network within 50 miles or 50 minutes of each enrollee's residence or work site, to the extent services are available.

Although these requirements were met in each county by each health option offered by the Commonwealth in 2001, there was an Eastern Kentucky county where the lowest cost Option A did not have the county's hospital in its network. Additionally, in a few Western Kentucky counties, the physician network of the lowest cost Option A offering included only a small percentage of the physicians practicing in those counties. This led the Commonwealth to strengthen the network requirements for the Public Employee Health Insurance Program beyond those required by statute. In its 2002 health insurance Request for Proposals, the Commonwealth stipulated that a bidder would only be qualified to offer coverage in a given county, if the bidder's provider network met the following requirements:

- The network must include at least one county hospital, if one or more hospitals exist in the county and any bidder for that county has at least one county hospital in its network.
- The physician network for the county must include at least 25% of the largest number of physicians reported by any bidder for that county.

Even with these more stringent network requirements, there were some Western Kentucky counties where the physician network of the lowest cost Option A offering was not viewed favorably by members of the Public Employee Health Insurance Program and Legislators in that area. In response to these concerns, the Commonwealth revised the network qualification requirements in its 2003 health insurance Request for Proposal as follows:

- The network must include at least one county hospital, if one or more hospitals exist in the county and any bidder for that county has at least one county hospital in its network.
- The physician network for the county must include at least 25% of the largest number of primary care physicians reported by any bidder for that county.
- The physician network for the county must include at least 40% of the largest number of specialist physicians reported by any bidder for that county.

The 2003 network qualification requirements resulted in the discontinuation of some health plan offerings in some counties, which were preferred by Commonwealth Group members.

Therefore, the Board reviewed the Commonwealth's network qualification standards. In this review, the health plans providing insurance to the Public Employee Health Insurance Program outlined the difficulties they encounter in keeping their physician provider directories current, particularly when physicians open new locations or shut down locations in counties outside their primary practice location. Based on this feedback, the Board recommends that the Commonwealth's 2003 network qualification standards be revised to only apply the specialist physician requirement in counties where at least one bidder has ten or more specialists in its network.

Self Funding

Description

Employee health insurance programs for which the sponsoring employer assumes the financial risk for the cost of medical services received by plan participants (claims) are termed "self-funded" programs. The liability assumed by a self-funded group includes all claims actually paid during a plan year, as well as those claims incurred during the year but not yet paid as of the last day of the plan year.

Under a self-funded arrangement, the risk for claim fluctuations, both positive and negative, would be transferred from the health plans that currently insure the Commonwealth's Public Employee Health Insurance Program to the Commonwealth, except as may be limited through the purchase of some form of stop-loss insurance. Additionally, unless fiduciary responsibility is delegated to a third party administrator (TPA), the Commonwealth would ultimately be responsible for decisions involving claim payments and other administrative determinations associated with the program.

Although it is far more common for indemnity and PPO plans to be self-funded than HMO options, self-funding is *not* limited to indemnity and/or PPO style plans. HMO and POS plans may also be self-funded, particularly for larger groups in health plans where few, if any, services are capitated.

Advantages and Disadvantages

Key advantages and disadvantages of self-funding are outlined below.

Advantages

- When claims are less than projected, the self-funded plan (or the employer) benefits rather than an insurance carrier.
- In the early months of a self-insured arrangement (the terms "self-funded" and "self-insured" may be used interchangeably), claims incurred prior to the effective date of self-funding are paid from the prior insured plan's reserves. This results in an immediate cash flow advantage to the self-insured plan, which should be the source for establishing a reserve for claims incurred but not yet paid.
- In addition to the cost of medical services received by plan participants, both insured and self-funded plans incur administrative expenses for claims payment and other administrative services necessary to operate the plan. However, administrative expenses under a self-funded arrangement are typically lower due to the elimination of insurer risk charges that are normally 2-5% of total premiums. Additionally, assuming that claim reserves are invested by the self-funded plan, the interest earned on these reserves will likely exceed the interest credits, if any, included in the insured plans' rate determinations.

- A higher percentage of prescription drug formulary rebates, usually 2-3% of pharmacy claims or .4% to .6% of total claims, are normally credited to the plan sponsor under a self-funded arrangement than under an insured arrangement.
- A self-funded program may have more negotiation flexibility with providers. Through direct contracting, a self-funded program may be able to include more providers in the plan's network, albeit at a higher cost to the plan.
- A self-funded program typically has more design flexibility. For example, a self-funded employer can offer options with HMO style benefits in areas where HMOs do not exist. This may result in more consistency in the benefit options offered to plan participants in different geographic areas of the Commonwealth.
- Currently, the Commonwealth's health insurance risk pool is split among five insurance carriers, segmenting its risks based on plan availability by geographic area and individual employees/retirees' selections. Under a self-funded arrangement, the Commonwealth could consolidate its risk pool and have increased flexibility in allocating its healthcare program's costs. By consolidating its health insurance risk into a single risk pool, the Commonwealth could eliminate regional health insurance option and employee contribution variations. However, this would likely result in fewer health options in some areas and higher employee contributions in some areas than under the current arrangement.
- By self-funding, employers increase their ability to carve out segments of their healthcare program, like pharmacy benefit management, behavioral health services or care/health management to customize the program to meet their specific requirements. Through these carve out arrangements, greater consistency in plan administration, including items like prescription drug formulary changes, may be achieved.

Disadvantages

- The financial risk an employer assumes is the biggest drawback to self-funding. In a self-funded arrangement, if claims and expenses exceed projections, it is the employer that must absorb the deficit. Given the magnitude of the Commonwealth's healthcare program's total expenditures, if claims and expenses exceeded projections by only 5%, a deficit of over $30 million would result. This level of variance or more is possible, particularly in the first year of self-funding due to the number of changes that are likely to occur in:
  - Provider network composition and therefore charges and practice patterns;
  - Provider reimbursement arrangements, if networks change; and
  - Claims and care management, if vendors managing the program change.
- It is essential to establish and maintain adequate claim reserves to properly fund a self-insured plan's obligations. Any pressure to use healthcare program reserves for other purposes must be resisted, if the program is to be financially sound. If reserves reach excessive levels, careful management is required to maintain stability in employee contribution amounts, particularly given that the Commonwealth does not currently explicitly subsidize the cost of dependent healthcare coverage.

- Under a self-funded arrangement, the Commonwealth may not be able to duplicate the current provider networks in place. If this occurs, the relationship between a patient and his/her healthcare provider(s) may be disrupted.
- While self-funding may increase the Commonwealth's flexibility in negotiating with healthcare providers and the options offered to its members, this flexibility could result in increased health plan costs for the Commonwealth and its employees/retirees.
- Insured plans resolve contested or unusual claims and act as a third-party buffer for the employer. Unless the Commonwealth delegates fiduciary responsibility for claim determinations and payments to the third party administrator, under a self-funded arrangement, the Commonwealth would be faced with making these determinations. Claim denials may be directly attributed to the Commonwealth and have the potential for causing increased employee dissatisfaction or increased pressure to pay ineligible expenses, thereby increasing plan expenditures. Additionally, legal actions taken by plan members could include the Commonwealth.
- The Commonwealth's current program structure supports regional health plans for which the Commonwealth Group comprises 70% or more of some plans' enrollment. In aggregate, the Commonwealth Group comprises about 20% of the health insurance market in Kentucky.[3] If the Commonwealth were to self-fund the Commonwealth's Public Employee Health Insurance Program, it could adversely impact the health insurance market for all Kentucky health insurance consumers.

Considerations

In addition to the advantages and disadvantages outlined above, the Commonwealth should consider the following in reaching a decision whether to self-fund its employee healthcare program:

- Actuarial assistance will be required to establish funding rates (pseudo premium rates) that can be expected to cover the claims paid by the health plan and administrative expenses of the plan and to establish adequate reserves for claims incurred but not yet reported or paid by the plan.
- Many self-funded health plans obtain stop-loss coverage to limit their maximum liability. Stop-loss coverage is basically insurance that covers expenses above a specified amount, either for each covered individual (specific coverage) or for the plan as a whole (in aggregate). However, given the size of the Commonwealth Group, it is anticipated that the premiums paid for stop-loss coverage would exceed any reimbursements received from the insurance carrier.
- When self-funded, a health plan becomes subject to Internal Revenue Code Section 105(h) non-discrimination rules. Given the current structure of the Commonwealth's Public Employee Health Insurance Program, this should not create a problem. However, this provision would need to be considered, if any revisions to the plan were considered that would discriminate in favor of highly compensated employees as defined by Section 105(h). It also would need to be taken into account, if the Commonwealth becomes involved in

[3] *Department of Insurance*

decisions as to whether to cover questionable expenses under the plan for highly compensated individuals or their family members.

- Reserves must be established and maintained in a sufficient amount to cover medical services that have been received, for which payments have not yet been made. This requirement is addressed in more detail in the section titled *Funding Requirements* which follows.
- The Commonwealth would need to assume responsibility for new functional requirements. These requirements and associated staffing implications are outlined in the section titled *Staffing Requirements.*

2003 Health Insurance Bids

In the 2003 health insurance Request for Proposal (RFP), the Commonwealth asked bidders to quote both self-funded and insured arrangements. The Commonwealth only received one qualified self-funded statewide bid. This bid was limited to PPO and EPO coverage options.

The 2001 incurred claims for the Public Employee Health Insurance Program, as reported by the Commonwealth's health insurance carriers, were projected forward to 2003 assuming 14% health insurance cost trend per year. Adding the projected 2003 claims to the administrative fees and specific stop-loss premiums quoted by the qualified self-funded bidder, the Commonwealth's 2003 cost was projected to be from 16% to 26% higher than it would be under the final insured bids received for 2003 under the Commonwealth's current structure. This cost differential does not take into account the additional cost to the Commonwealth for the administrative requirements it would assume under a self-funded arrangement. (See the Staffing Requirements section for additional information.)

Funding Requirements

Reserves must be established and maintained in a sufficient amount to cover medical services that have been received, but for which payments have not yet been made. Care must be taken to maintain reserves at an adequate but not excessive level. Based on the experience reported by the Commonwealth's insurance carriers, this reserve would need to be about 18-20% of paid claims or around $120 million for calendar year 2003.

In years when the reserves held exceed needed levels (surplus) or are below the required amount (deficit) careful consideration will be needed in determining how to spend down the surplus or fund the deficit, including how individual entities that participate in the Commonwealth Group will be affected. The rates required to fund claims and expenses for future periods should be developed based on expected future claims and expenses irrespective of reserve deficits or surpluses. To the extent possible, reserve surpluses and deficits should be addressed independently of future funding rates.

If reserve surpluses are taken into account in establishing funding rates for a period and experience develops as expected, funding rates for the subsequent period would need to be increased by both the surplus taken into account for the current period and expected inflation. If they are not, a deficit will result in the subsequent period. This is similar to the experience of Kentucky Kare in the years following 1993 when policymakers decided to place a moratorium on premium increases until its reserves were reduced.

If reserve deficits are taken into account in establishing funding rates for a period and experience develops as expected, the funding rate increase for the subsequent period would be offset by the deficit recouped in the current period. This may result in sea-sawing medical rates. This is illustrated by the following example:

- Suppose projected costs for 2002 were $500 million based on an aggregate, annual funding rate of $5,000 for 100,000 enrollees. However, actual expenses for 2002 were $600 million, generating a deficit of $100 million or 20%.
- Assuming medical inflation of 10% from 2002 to 2003, the projected composite annual rate, including full deficit recoupment, would be $7,600 for 2003 – $6,600 to fund expenses expected to be incurred in 2003 ($6,000 x 110%) plus $1,000 to fund the deficit ($100 million divided by 100,000 enrollees). In essence, funding rates would have increased 52% from 2002 to 2003.
- If actual expenses for 2003 were $660 million as expected and medical inflation was expected to be 10% from 2003 to 2004, the 2004 composite annual funding rate per enrollee would be $7,260 ($6,600 x 110%), a reduction of about 4.5%.
- If actual expenses in 2004 were $726 million as expected, the composite annual funding rate for 2004 would need to increase by the expected medical trend from 2004 to 2005. If this were 10%, the annual funding rate per enrollee would increase 10%.

Staffing Requirements

Under a self-funded arrangement, the Commonwealth would need to assume responsibility for new functional requirements that are not present today:

- establishing and maintaining a "fund" to hold reserves;
- setting up banking procedures for remittance of administrative expenses and claim payments to the third party administrator(s) the Commonwealth selects to pay its healthcare claims; and
- implementing centralized facility(ies) to determine the "premiums" due each month from each entity participating in the Commonwealth's Public Employee Health Insurance Program, collecting "premiums" from each entity, reconciling premiums received with each entity's eligibility information, remitting monthly payments for administrative expenses and weekly or daily payments for claims to the Commonwealth's third party administrator(s), and reconciling the balance in the reserve fund.

New procedures would need to be established and additional staffing obtained to support these additional functional requirements.

Findings

- Based on the Commonwealth's 2001 survey of other states, the majority of other states (72%) self-fund at least one of their health insurance options. However, only 15% self-fund their entire health insurance program.
- The Commonwealth's insured funding arrangement is consistent with other states in view of the plan types it offers to employees and the heavier concentration of Commonwealth Group members enrolled in HMOs.

- Seventy-six percent of other states responding to the Commonwealth's 2001 survey insured all of their HMO offerings. Another 12% insured some of their HMO offerings and self-fund other HMO options. Only 12% self-funded all of their HMO offerings.
- For POS and PPO options, other states were split roughly in half regarding their funding arrangement – insured vs. self-funded.

- The advantages and disadvantages of self-funding are outlined in Exhibit XVIII.

Exhibit XVIII

Self-Funding Advantages and Disadvantages	
Advantages	**Disadvantages**
▪ Lower expected administrative costs ▪ Larger formulary rebate credits ▪ Negotiation flexibility ▪ Design flexibility ▪ Cost allocation flexibility ▪ Customization ability ▪ Potential for increased consistency	▪ Risk assumption – deficit potential ▪ Reserve management ▪ Patient/provider disruption potential ▪ Unavailability of some plan choices ▪ Loss of third party buffer ▪ Impact on Kentucky insurance market ▪ Potentially, increased claim costs due to negotiation/design flexibility ▪ Additional Commonwealth staffing required

Source: Mercer Human Resource Consulting, Inc.

- Results of the 2003 health insurance bidding process indicate that the Commonwealth's 2003 health insurance costs would be 16% to 26% higher, if the Public Employee Health Insurance Program were self-funded rather than insured under its current arrangement.

Legislative Mandates

The Department of Insurance provided the summary in Exhibit XIV of twenty-nine mandated health insurance benefits that currently exist in Kentucky's statutes.

Exhibit XIV

Kentucky Mandated Health Insurance Benefits	
Newborn Coverage	KRS 304.17-042, KRS 304.18-032, KRS 304.32-153, and KRS 304.38-199. Coverage for newborn children from the moment of birth, including necessary care and treatment of medically diagnosed inherited metabolic diseases for newborns—KRS 304.17A-139(2)
Inherited Metabolic Disease	KRS 304.17A-139(4). Coverage for amino acid modified preparation and low protein modified food products for treatment of inherited metabolic diseases for conditions listed in KRS 205.560, if prescription drugs are covered. Benefits can be limited to $4,000 per year for low-protein modified foods and $25,000 per year for medical formulas.
Ambulatory Surgical Centers	KRS 304.17-317, KRS 304.18-035, & KRS 304.32-156. Coverage for treatment at ambulatory surgical centers.
Optometrists, osteopaths, physicians, podiatrists, and chiropractors	KRS 304-17-035, KRS 304.18-095, KRS 304.32-157 & KRS 304.38-195. KRS 304.17A-275 requires that coverage be provided for services provided by osteopaths. Osteopaths can also be PCP's. Services of these providers to be covered as described.
Chiropractors	KRS 304.17A-170 & 171. Access to chiropractors in network plans.
Dentists	KRS 304.17-315, KRS 304.18-097, KRS 304.32-157 & KRS 304.38-1937. Services of dentists to be covered as described.
Temporomandibular Joint Disorder	KRS 304.17-319, KRS 304.18-0365, KRS 304.32-1585 & KRS 304.38-1937. Coverage for specific services related to TMJ and associated disorders. Also see Administrative Regulation 806 KAR 17:090.
Screening Mammography	KRS 304.17-316, KRS 304.18-098, KRS 304.32-1591 & KRS 304.38-1935. Screening mammography at specific intervals. KRS 304.17-316(2)(b) requires mammography coverage at any age for a covered person diagnosed with breast cancer.
Breast Cancer	KRS 304.17-3165, KRS 304.17A-135, KRS 304.18-0985, KRS 304.32-1595 & KRS 304.38-1936. Coverage for the treatment of breast cancer, including ABMT.
Breast reconstruction coverage, endometriosis and endometritis	KRS 304.17-3163, KRS 304.18-0983, KRS 304.38-1934, KRS 304.32-1593 & KRS 304.17A-134.
Psychologists and Clinical	KRS 304.17-3185, KRS 304.18-0363, KRS 304.32-166 & KRS

Kentucky Mandated Health Insurance Benefits	
Social Workers	304.38-1933. Services of these providers to be covered as described.
Registered nurse first assistant benefits	KRS 304.17A-146. Health benefit plans that cover surgical first assisting benefits or services must provide coverage for a registered nurse first assistant who performs the services within the scope of their license.
Conversion benefits	2002 Ky. Acts, Chapter 351, Section 9. Maximum benefits of at least $500,000 for conversion policies—KRS 304.18-120(1). Minimum benefits—806 KAR 17:260.
Work Related Illness/Injuries	KRS 304.12-250. No contract can exclude coverage solely on the basis that the health condition is work related.
Disabled Children	KRS 304.17-310. Individual health insurance contracts must continue coverage for disabled children beyond the limiting age. Although this statute is applicable only to individual contracts, group carriers commonly use it.
Adopted Children	KRS 304.17-140. Coverage for legally adopted children or children under court-appointed guardianship.
Human Immunodeficiency Virus	KRS 304.12-013(5). No insurer or HMO may exclude or limit coverage for AIDS, etc.
Maternity Coverage	KRS 304.17A-145. Specified length of hospital stay following vaginal/cesarean deliveries.
Cochlear Implants	KRS 304.17A-131. Coverage for cochlear implants.
Autism	KRS 304.17A-143. Coverage for autism, including respite services.
Diabetes	KRS 304.17A-148. Coverage for diabetic services, supplies, and training.
Women's Health	KRS 304.17A-134, KRS 304.17-3163, KRS 304.18-0983, KRS 304.32-1593 & KRS 304.38-1934. Breast reconstruction, endometriosis, endometritis, and bone density testing.
Domestic Violence	KRS 304.17A-155. Claims may not be denied or considered pre-existing on the basis of domestic violence.
Hospice	KRS 304.17A-250(8). Coverage for hospice care equal to Medicare benefits.
Telehealth services	KRS 304.17A-138. (Effective when the plans are issued or renewed after July 15, 2001)
Mental health coverage	KRS 304.17A-661. Large group health benefit plans must cover mental illness the same as physical illness, if they provide mental illness benefits.
Physician assistant benefits	KRS 304.17A-1473. Health Benefit Plans that cover surgical first assisting or intraoperative surgical care services must provide coverage for the services of a physician assistant. (Effective for Health Benefit Plans issued or renewed on or after July 15, 2001.)

Kentucky Mandated Health Insurance Benefits	
Anesthesia and hospital or facility charges	2002 Ky. Acts, Chapter 199. Requires coverage for payment of anesthesia and hospital or facility charges in connection with dental procedures for children below the age of nine, persons with serious mental or physical conditions and persons with significant behavioral problems in all health benefit plans that provide coverage for general anesthesia and hospitalization services.
Hearing aids and related services	2002 Ky. Acts, Chapter 106, Section 1(2). Requires coverage for hearing aids and related services for persons under 18 years of age for the full cost of one hearing aid per impaired ear up to $1,400 every 36 months.

Source: Kentucky Department of Insurance

In addition to the mandated benefits outlined in Exhibit XIV, there are other statutory requirements that affect the Public Employee Health Insurance Program. Exhibit XV provides a brief outline of the key provisions of the mandates enacted by the 2000 General Assembly that apply to health insurance programs. The provisions of those bills for which there is no check mark in the column titled "Impacts Commonwealth Plan" were covered by the Commonwealth's Public Employee Health Insurance Program prior to the enactment of the mandate.

Exhibit XV

	Health Insurance Mandates Enacted by 2000 General Assembly	
	Impacts Commonwealth Plan	Key Provisions
HB 9		Mammography coverage
HB 177		Coverage of telehealth services
HB 202	✓	▪ Newborn coverage from moment of birth ▪ Treatment of inherited metabolic diseases including amino acid preparations and low-protein modified food products
HB 268	✓	Mental Health Parity
HB 281		Coverage of services provided by registered nurse first assistants
HB 390	✓	▪ Utilization review rules ▪ Independent external review
HB 757	✓	▪ Hold harmless and continuity of care upon contract termination ▪ Drug formulary summary required at enrollment ▪ Network access requirements modified ▪ Prudent lay person standard for emergency services
SB 279	✓	Prompt payment of medical claims
SB 335	✓	Coverage of certified surgical assistants

These mandates first applied to the Commonwealth's health insurance program effective January 1, 2001. From the claims experience reported by the Commonwealth's health insurance carriers for 2001, aggregated by MedStat, payments attributable to the Mental Health Parity provisions of

HB 268 added about one-tenth of one percent to the Commonwealth's 2001 Public Employee Health Insurance Program claims. Coverage of amino acid preparations and low-protein modified food products for individuals with inherited metabolic diseases under HB 202 added less than one-tenth of one percent to the Commonwealth's 2001 Public Employee Health Insurance Program costs. While the discernible cost of these mandates was low in 2001, based on available data, significant variation can result from year to year. Additionally, the ability to determine the cost of discrete provisions, such as these, is highly dependent on providers appropriately classifying the expenses and insurance carriers accurately recording the expenses. Therefore, the cost impact can easily be understated.

It is not possible to discern the cost impact the other mandates enacted by the 2000 General Assembly had on the Commonwealth's Public Employee Health Insurance Program.

In addition to the health insurance mandates, Senate Bill 288, enacted by the 2000 General Assembly:

- Created the Kentucky Group Health Insurance Board.
- Required the Personnel Cabinet to develop healthcare data collection and analysis capabilities.
- Stipulated the conditions under which groups may leave the Public Employee Health Insurance Program.
- Revised the definition of "employee" with respect to the Commonwealth's healthcare and flexible spending account benefits.
- Required the Personnel Cabinet to report annually to the General Assembly on the financial stability of the Commonwealth's Public Employee Health Insurance Program.
- Required unused flexible spending account funds to be transferred to the state health insurance plan's appropriation account.
- Required carriers bidding to offer healthcare coverage to members of the Public Employee Health Insurance Program to rate all such members as single entity, except for those retirees whose former employers insure their active employees outside the Public Employee Health Insurance Program.
- Precluded certain individuals who are eligible for participation in the Public Employee Health Insurance Program as a retiree from receiving the state health insurance contribution as an active employee as well.

Additional mandates enacted by the 2001 and 2002 General Assemblies affect the Commonwealth's Public Employee Health Insurance Program. These are summarized briefly in Exhibit XVI. As these mandates first impact the Commonwealth's program on or after January 1, 2002, definitive information on their impact on the program is not yet available. However, based on 2002 enrollment, it is estimated that the contiguous county provision attached to House Bill 846 and House Bill 821 will increase the Commonwealth's 2003 health insurance cost by about $2.5 million.

Exhibit XVI

Legislation Enacted by the 2001 and 2002 General Assemblies that Impacts the Public Employee Health Insurance Program		
Year Enacted	**Bill**	**Key Provisions**
2001	HB 97	The Office of Public Employee Health Insurance was established under the Personnel Cabinet.
2001	HB 138	Coverage of physician assistants assisting in surgery.
2001	HB 145	Personnel Cabinet and Cabinet for Families and Children to prepare recommendations regarding allowing foster parents to participate in the Public Employee Health Insurance Program.
2002	HB 39	Coverage of anesthesia and hospital or facility charges in connection with dental procedures for children below the age of nine, persons with serious mental or physical conditions and persons with significant behavioral problems.
2002	HB 163	Expands Kentucky Group Health Insurance Board to include: ▪ The Director of the Administrative Office of the Courts ▪ KRS retiree ▪ KTRS retiree ▪ Active teacher ▪ Active state employee ▪ Active classified education support employee
2002	HB 369	Mail order prescription drug coverage for Public Employee Health Insurance Program.
2002	HB 395	Revised caps for inherited metabolic diseases to be $4,000 annually for low-protein modified foods and $25,000 annually for medical formulas.
2002	HB 801	Entities that join the Kentucky Retirement System must join the Public Employee Health Insurance Program for their active employees.
2002	HB 821	▪ Personnel Cabinet to study whether to allow health insurance bidders to bid different rates in different geographic areas of the Commonwealth. ▪ Allows Public Employee Health Insurance members to select coverage in a contiguous county and receive the state contribution for that county if the hospital in the county where the member lives and works does not offer certain services and a hospital in the contiguous county does.
2002	HB 846	▪ Restricts individuals to one state contribution for health insurance. ▪ Entities participating in the Public Employee Health Insurance Program must sign a contract with the Personnel Cabinet. ▪ Expands the Advisory Committee of State Health Insurance Subscribers to include 2 members from the Kentucky Association of Counties and 2 from the Kentucky League of Cities. ▪ Directs the LRC to study the cost to members of the state health insurance group as a result of entities covering their retirees under the Public Employee Health Insurance Program but not their active employees and recommend administrative procedures to collect this cost from these entities.

Legislation Enacted by the 2001 and 2002 General Assemblies that Impacts the Public Employee Health Insurance Program		
Year Enacted	**Bill**	**Key Provisions**
2002	HB 846	▪ Directs the LRC to study the Public Employee Health Insurance Program. ▪ Allows Public Employee Health Insurance members to select coverage in a contiguous county and receive the state contribution for that county if the hospital in the county where the member lives and works does not offer certain services and a hospital in the contiguous county does.
2002	SB 152	Coverage for hearing aids and related services for persons under 18 years of age for the full cost of one hearing aid per impaired ear up to $1,400 every 36 months.
2002	SCR 34	Directs the Interim Joint Committee on Banking and Insurance to study the feasibility of self-funding at least one health insurance option for state employees.

Summary of Findings

This section provides a consolidated summary of the key findings presented in the previous sections of this report. The Board's recommendations, based on these findings, are outlined in the Executive Summary.

Outstanding 2001 Board Recommendations

The majority of the Board's 2001 recommendations have been accomplished. However, there are several key recommendations that are still outstanding:

- Restrict funds appropriated by the Commonwealth for employee/retiree health insurance to use for employee/retiree healthcare benefits. Therefore, consistent with KRS 18A.225(2)(g), recoup forfeitures from the healthcare flexible spending accounts funded by the Commonwealth, for those who waive health insurance, from ***all*** entities that participate in the Commonwealth Group and return these to the Commonwealth's Public Employee Health Insurance Program, to the extent permissible by federal standards.
- To make health insurance coverage more affordable for employees' dependents and to bring the Commonwealth's program more in line with those of other states, subsidize the cost of dependent health insurance premiums, to the extent financially feasible without impacting the ability to provide Single coverage under the lowest cost Option A at no employee contribution.
- Investigate pharmacy initiatives such as purchasing pools, co-pay/co-insurance structures, multiple tiers, etc. to obtain the most cost effective prescription drug benefits for the Commonwealth's Public Employee Health Insurance Program and its members.
- Retirees of groups whose active employees do not participate in the Commonwealth's Public Employee Health Insurance Program, and their covered dependents, added about $15-$16 million in excess cost that was absorbed by the Commonwealth or other Commonwealth Group members in 2001.[1] Therefore, either:

  Require the active employees of all entities whose retirees participate in the Commonwealth's Public Employee Health Insurance Program to also participate.

  or

  Require entities whose retirees participate in the Commonwealth's Public Employee Health Insurance Program to be responsible for the actuarial difference in cost of their retirees.
- Only self-fund the Public Employee Health Insurance Program, if it is highly likely that the risk the Commonwealth would be accepting would be offset by substantial cost savings, after taking into account not only projected claims, re-insurance premiums and third party administrator costs, but also the cost of the additional Commonwealth staff required. Also,

[1] *Calculated by Mercer Human Resource Consulting from data compiled by the MedStat Group as submitted by the health plans providing health insurance to the Public Employee Health Insurance Program.*

consider the impact on the overall health insurance market in Kentucky, if the Public Employee Health Insurance Program were to self-fund, since the Commonwealth comprises approximately 20% of the individuals with insured healthcare benefits in the entire state.

- As part of continuous quality improvement, conduct on-site reviews to validate performance results reported by the Commonwealth's Public Employee Health Insurance Program insurance carriers and/or third party administrators, including:
  - claims and eligibility audits to assess the timeliness, financial accuracy and claim coding accuracy of claims processed;
  - operational reviews to evaluate staffing, systems, policies and procedures; and
  - customer service assessments to determine the quality and timeliness of customer service delivered to Commonwealth Group members.

2001 Public Employee Health Insurance Key Trends

- The Commonwealth's 2001 premium increase of 9.1% is lower than the cost increase reported by employers that participated in the *Mercer/Foster Higgins National Survey of Employer-Sponsored Health Plans for 2001.* Survey respondents reported aggregate healthcare costs increases of:
  - 12.1% nationally for employers in all industry groups with 500 or more employees,
  - 13.8% for state government employers, and
  - 12.7% for employers located in the South (U.S. census region) with 500 or more employees.

  However, fueled by increases in prescription drug expenditures of 20.8%, aggregate payments issued to healthcare providers who provided medical supplies and services to members of the Commonwealth's Public Employee Health Insurance Program increased 14.4%, a faster pace than experienced by respondents to Mercer's survey.
- As payments for the medical supplies and services received by Commonwealth Group members increased at a faster pace than premiums paid to the Commonwealth's health insurance carriers, the plan's overall loss ratio increased from 86.4% in 2000 to 90.5% in 2001. In 2001, a greater share of the Commonwealth's and Commonwealth Group members' premium payments went to pay healthcare providers than in 2000, leaving a smaller percentage of premium dollars to pay the insurers' operating expenses and contribute to their profits.
- The number of individuals electing Family and Parent Plus coverage continues to decline. While the number of employees and retirees insured under the Commonwealth's health insurance program increased 2.2% in 2001, due to a decline in the number of individuals electing dependent healthcare coverage, the total number of covered lives remained virtually the same as in 2000.
- The number of active employees, excluding covered dependents, insured under the Commonwealth's health insurance program increased, on average, by roughly 700 individuals from 2000 to 2001. However, the number of covered retirees, excluding covered dependents, increased, on average, by almost 2,000. Retirees and their covered dependents comprised 14.3% of the total insured Commonwealth Group in 1999. This grew to 17.0% in

2001. This trend has long-term cost implications for the Public Employee Health Insurance Program.

- HMO enrollment remained relatively steady at around 50% of the group, although there was a slight decline in the percentage of Commonwealth Group members enrolled in HMO A (about 7/10ths of one percent) with a corresponding increase in HMO B enrollment. Point of Service (POS) enrollment continues to decline dramatically, from 33% in 1999 to 28% in 2000 and 22% in 2001. This decline was offset by increases in Preferred Provider Organization (PPO) enrollment. PPO enrollment grew from roughly 20% in 2000 to over 26% in 2001, with the majority of this increase occurring in PPO option A in which enrollment grew from 18.5% to 24.4%. Enrollment in the Exclusive Provider Option implemented by the Commonwealth January 1, 2000 declined slightly, less than 100 employees/retirees.
- The primary change in enrollment by insurance carrier from 2000 to 2001 resulted from the re-entrance of Aetna as an offering in 2001. Around 12% of Commonwealth employees/retirees migrated to Aetna in 2001. Additionally, enrollment in Bluegrass Family Health increased from about 27% in 2000 to a little over 29% in 2001, due to Bluegrass Family Health's expansion into nine additional counties of the Commonwealth coupled with the withdrawal of CHA from 19 counties. Enrollment declines for the other carriers offering coverage to Commonwealth Group members were are follows:
  - Anthem declined from roughly 24% in 2000 to 22% in 2001,
  - CHA declined from about 25% to 21%, and
  - Humana declined from 17.5% to about 16%.
- The 2001 per capita increase in prescription drug expenditures in the Public Employee Health Insurance Program of 20.8% was higher than reported by participants in the *Mercer/Foster Higgins National Survey of Employer-Sponsored Health Plans for 2001*. Survey respondents reported aggregate prescription drug costs increases of:
  - 17.8% nationally for employers in all industry groups with 500 or more employees,
  - 18.2% for state government employers, and
  - 17.9% for employers located in the South (U.S. census region) with 500 or more employees.

  Note: The increases reported by survey respondents reflect the net increase in cost after taking into account the increases in prescription drug co-payments implemented by some survey respondents.

  Although the Commonwealth improved the prescription drug benefit in its PPO B option in 2001, enrollment in this option is only 2% of the total group. Therefore, this change had a negligible impact on the Commonwealth's 2001 prescription drug costs. Based on data reported by the Commonwealth's insurance carriers and aggregated by MedStat, the increase is attributable to four quantifiable factors:
  - an increase in unit price per prescription for the same drug – accounted for a 5.7% increase in prescription drug costs,
  - a change in the mix of drugs received by Commonwealth Group members – accounted for a 3.1% increase in prescription drug costs,

- co-payment leveraging, the impact of fixed dollar co-payments on the Commonwealth's health plan's cost in relation to unit price increases – which accounted for an increase of 2.3%, and
- utilization – an increase of 7.8%.

Regional Variations within the Commonwealth

- Due to regional differences in the health care costs of Commonwealth Group members and/or the ability of insurance carriers to obtain contracts with providers in certain areas of the state, the health plan choices and employee contributions for dependent health insurance coverage currently vary across the state.
- Under its current funding arrangement, it is extremely difficult for the Commonwealth to offer the same health plan choices at the same cost in every county of the Commonwealth. While this goal could be achieved if the Commonwealth self-funded its program, it would result in fewer carrier choices in some counties and higher costs in some counties.

Market Comparison

In some respects, the Commonwealth's health insurance program is more generous than the typical program of other states:

- The Commonwealth provides a $234 monthly contribution to a healthcare flexible spending account for eligible employees who waive health insurance through the Public Employee Health Insurance Program. In comparison only four of thirty-six states in the Commonwealth's 2001 survey provided an alternative benefit to individuals who waive health insurance. The alternative benefits reported include: a $25 monthly flexible spending account contribution, a $108 monthly cash option and a $128 flex credit.
- The Commonwealth pays the full cost of Single coverage under the lowest cost Option A for employees and retirees with 20 or more years of service. Only 38% of other states in the Commonwealth's 2001 survey reported that they paid the full cost of employee only health insurance premiums.
- The Commonwealth has more liberal retiree health insurance provisions.

These differences are very similar to those between the Commonwealth's program and large, private sector Kentucky employers.

Other aspects of the Commonwealth's program are less generous than other states' and large, private sector Kentucky employers programs, most notably, the lack of explicit dependent subsidies in the Commonwealth's program.

In essence, the Commonwealth has chosen to allocate its health insurance funding in a different manner than the typical state or large, private sector Kentucky employers.

The Commonwealth's Provider Network Requirements

- Although the Commonwealth has modified its network qualification requirements twice to address concerns of some Legislators and Public Employee Health Insurance members, the requirements in the Commonwealth's 2003 health insurance RFP resulted in the discontinuation of some health plan offerings in some counties, which were preferred by Commonwealth Group members.

- The health plans providing insurance to the Public Employee Health Insurance Program have indicated that it is difficult for them to keep their physician provider directories completely accurate and current, particularly when physicians open new locations or shut down locations in counties outside their primary practice location.

Self Funding

- Based on the Commonwealth's 2001 survey of other states, the majority of other states (72%) self-fund at least one of their health insurance options. However, only 15% self-fund their entire health insurance program.
- The Commonwealth's insured funding arrangement is consistent with other states in view of the plan types it offers to employees and the heavier concentration of Commonwealth Group members enrolled in HMOs.
  - Seventy-six percent of other states responding to the Commonwealth's 2001 survey insured all of their HMO offerings. Another 12% insured some of their HMO offerings and self-fund other HMO options. Only 12% self-funded all of their HMO offerings.
  - For POS and PPO options, other states were split roughly in half regarding their funding arrangement – insured vs. self-funded.

- The advantages and disadvantages of self-funding are outlined below.

Self-Funding Advantages and Disadvantages	
Advantages	**Disadvantages**
▪ Lower expected administrative costs	▪ Risk assumption – deficit potential
▪ Larger formulary rebate credits	▪ Reserve management
▪ Negotiation flexibility	▪ Patient/provider disruption potential
▪ Design flexibility	▪ Unavailability of some plan choices
▪ Cost allocation flexibility	▪ Loss of third party buffer
▪ Customization ability	▪ Impact on Kentucky insurance market
▪ Potential for increased consistency	▪ Potentially, increased claim costs due to negotiation/design flexibility
	▪ Additional Commonwealth staffing required

Source: Mercer Human Resource Consulting, Inc.

- Results of the 2003 health insurance bidding process indicate that the Commonwealth's 2003 health insurance costs would be 16% to 26% higher, if the Public Employee Health Insurance Program were self-funded rather than insured under its current arrangement.

Legislative Mandates

There are many statutes that affect the Public Employee Health Insurance Program. While the impact of many of these mandates on the program's costs are difficult to discern, estimates of the impact of a few are provided below:

- From the claims experience reported by the Commonwealth's health insurance carriers for 2001, aggregated by MedStat, payments attributable to the Mental Health Parity provisions of HB 268 added about one-tenth of one percent to the Commonwealth's 2001 Public Employee Health Insurance Program claims.
- Coverage of amino acid preparations and low-protein modified food products for individuals with inherited metabolic diseases under HB 202 added less than one-tenth of one percent to the Commonwealth's 2001 Public Employee Health Insurance Program costs.
- It is estimated that the contiguous county provision attached to House Bill 846, enacted by the 2002 General Assembly, will increase the Commonwealth's 2003 health insurance funding by about $2.5 million.
- While the discernible cost of some mandates may be low in a given year, significant variation can result from year to year. Additionally, the ability to determine the cost of discrete provisions is highly dependent on providers appropriately classifying the expenses and insurance carriers accurately recording the expenses. Therefore, the cost impact can easily be understated.

Glossary

Allowed Charge – The amount paid in total to a healthcare provider for services received by a health plan member. This amount includes both the health plan's payment and the member's cost sharing (deductible, co-payment, co-insurance, etc.). This is the total amount billed by a healthcare provider for a covered service, after the application of the health plan's negotiated discount, but prior to any member cost-sharing.

Brand Name Drug – A trademarked drug for which the manufacturer holds the patent or has purchased the rights to manufacture from the patent holder. Brand name drugs are generally more expensive than generics.

Capitation – A set amount of money paid to a provider of service based on membership demographics rather than payment based on services provided.

Claim – A billed amount for services or goods obtained from a healthcare provider.

COBRA Beneficiaries - Individuals who no longer meet the eligibility requirements for healthcare coverage through a group health plan, but by federal statute, are eligible to continue their healthcare coverage for a period of time under the employer's healthcare program by paying 102% of the total premium rate.

Co-Payment – A stipulated dollar amount that a health plan member must pay out of pocket when healthcare services, supplies, or prescription drugs are received.

Coinsurance – A percentage of the cost of covered healthcare services, supplies, or prescription drugs that a health plan member must pay out of pocket.

Coverage Tier also referred to as Coverage Level – The choices available to employees with respect to the individuals they wish to cover under an employer's health insurance program. Under the Commonwealth's Public Employee Health Insurance Program, the following tiers (or levels) apply:

- Single – coverage for only the employee or retiree
- Couple – coverage for the employee or retire and his/her spouse
- Parent Plus – coverage for the employee and all eligible children
- Family – coverage for the employee or retiree, his/her spouse and all eligible children

Dependent Subsidy – When an employer specifically pays a portion, or all, of the dependent premium for an employee, this is an *explicit dependent* subsidy. When the differential between single and dependent healthcare premium rates is less than the differential between employee/retiree healthcare claims and dependents' healthcare claims, an *implicit dependent subsidy* exists.

EPO – Exclusive Provider Organization - These plans require services to be received from a healthcare provider that participates in the health plan's network in order for the service to be covered by the plan. Depending on the insurance carrier chosen, the participant may or may not have to designate a primary care physician to coordinate his/her care. Beginning January 1, 2000, EPO Option C was added to the Commonwealth's Public Employee Health Insurance Program.

Formulary – A preferred list of medications developed by a health plan or Pharmacy Benefit Manager (PBM) to guide physician prescribing and pharmacy dispensing. This list is periodically updated by the PBM to add or remove drugs.

FSA – Flexible Spending Account – A flexible spending account or reimbursement account is funded by employee salary reductions, employer contributions or both. Amounts placed in these accounts are used to provide reimbursement for eligible expenses incurred by the employee or eligible beneficiaries for specified benefits during a plan year.

Fully Insured - also referred to as Insured or Fully Funded - When a health plan assumes the financial risk associated with medical expenses for an employer group in exchange for the premiums paid by the group.

Generic Drug - A drug whose therapeutical ingredients are the same as a brand name drug, but which is sold under a name that is not trademarked. Generic drugs are usually less expensive than their brand name counterpart.

HMO – Health Maintenance Organization - These plans require services to be received from a healthcare provider that participates in the health plan's network in order for the service to be covered by the plan. Participants in these plans must select a primary care physician to coordinate their care. For the majority of the services covered by the HMO, participants pay a specified dollar amount (co-payment) at the time services are received.

Medical Loss Ratio also referred to as Loss Ratio - The ratio between the incurred claims paid by a health plan and the premium taken in by the health insurer. Example: An insurance company receives $100,000 in premium for a month and pays out $89,000 in claims – the Medical Loss Ratio is 89% ($89,000/$100,000).

Out-of-Pocket Limt – A specified dollar amount present in some health plan provisions that limits the amount of out-of-pocket expenses a plan participant pays in a Plan Year for covered health care services. Once the participant reaches the out-of-pocket limit, the health plan pays 100% of his/her covered healthcare expenses for most or all services.

PBM – Pharmacy Benefit Manager – An organization that functions as a third party administrator for a health plan's pharmacy claims, contracts and management.

POS – Point of Service - These plans mimic the benefits of the HMO options, provided an individual receives services from a healthcare provider that has contracted with the health plan and services are coordinated through the primary care physician designated by the individual. Unlike the HMO options, the POS options provide coverage for services received from a provider that is not in the health plan's network, at a higher cost sharing percentage to the insured.

Preferred Provider Organization (PPO) - These plans require lesser cost sharing from participants, if covered services are received from a healthcare provider that participates in the health plan's network. Coverage is provided for services received from a provider that is not in the health plan's network, with participants paying a larger proportion of the cost of covered services. Unlike POS plans, PPOs do not require referrals from a participant's primary care physician. The PPOs offered under the Commonwealth's Public Employee Health Insurance Program provide the same benefits for services received in a network physician's office and for prescription drugs as do the HMO and POS options. However, for services received in a network hospital or surgical center, PPO participants pay a percentage of the cost of services received (co-insurance) after paying an annual deductible, rather than a specified dollar co-payment. The amount of co-insurance that a participant pays annually is capped by the PPO plan's out-of-pocket limit.

Premium – The monetary amount paid by an employee or the employer for health insurance benefits. Routinely paid on a monthly basis. In an insured program, the amount paid to an insurance company in exchange for its payment of all healthcare costs covered under the terms of the health plan and for administrative services. For large groups, like the Public Employee Health Insurance Program, premiums are determined based on the healthcare services consumed by the plan's members in the past and the prices charged by healthcare providers. If the premiums charged by the insurer are less than the actual healthcare costs incurred by the plan's members and the insurer's operating costs, the insurer loses money. The premium includes both the employer's and employees' contributions for health insurance.

Primary Care Physician – For purposes of the applying the Commonwealth's qualifying network requirements, a primary care physician includes: family practice physicians, general practice physicians, pediatricians, and internists.

Provider Network – A list of contracted health care providers, unique to a health plan, from which an insured can obtain services that are covered under an HMO or are covered at a preferred benefit level under a POS or PPO.

Self Insured – also referred to as Self Funded – A health plan whose medical claims' financial risk is assumed by the employer and not by the health plan.

Specialist Physician – For purposes of the applying the Commonwealth's qualifying network requirements, a specialist physician includes all physicians other than: family practice physicians, general practice physicians, pediatricians, and internists.

Stop Loss Coverage - Stop loss coverage is insurance that covers a health plan's expenses above a specified amount, either for each covered individual (specific coverage) or for the plan as a whole (in aggregate). This coverage is also referred to as **Excess Loss Coverage.**

Third Party Administrator (TPA) – An organization that performs health insurance administrative functions (e.g. claims processing) for a plan or an employer. The TPA may also provide the healthcare provider network.

Waiver - An eligible employee or retiree who declines health care coverage through his/her employer for a plan year. Often the employee obtains health care coverage through another means, typically a spouse's employer or an individual.

States Included in Retiree Health Insurance Statistics

	Mercer Telephone Survey	Internet
Alabama		X
Alaska		X
Arizona		X
Arkansas	X	X
California		X
Delaware		X
Florida		X
Idaho		X
Illinois	X	X
Indiana	X	X
Iowa		X
Kansas		X
Maryland		X
Massachusetts		X
Michigan		X
Missouri	X	X
Montana		X
New Jersey		X
North Carolina	X	X
Ohio	X	X
Oregon		X
South Carolina	X	X
Tennessee	X	X
Texas	X	X
Virginia	X	X
Washington		X
Wisconsin		X

2002 Commonwealth Group Plan Choices By County

County	HMO	POS	PPO	EPO	Total
Adair	4	4	4	3	15
Allen	2	2	4	2	10
Anderson	6	6	4	3	19
Ballard	2	2	4	2	10
Barren	0	0	4	2	6
Bath	4	4	4	3	15
Bell	4	4	2	2	12
Boone	2	2	4	3	11
Bourbon	6	6	4	3	19
Boyd	0	0	2	1	3
Boyle	4	4	6	3	17
Bracken	4	4	4	3	15
Breathitt	4	4	4	3	15
Breckinridge	2	2	0	1	5
Bullitt	6	6	2	3	17
Butler	2	2	6	3	13
Caldwell	2	2	4	2	10
Calloway	2	2	4	2	10
Campbell	2	2	4	3	11
Carlisle	2	2	4	2	10
Carroll	4	4	2	2	12
Carter	0	0	2	1	3
Casey	4	4	4	3	15
Christian	0	0	2	1	3
Clark	6	6	4	3	19
Clay	4	4	2	2	12
Clinton	2	2	2	2	8
Crittenden	2	2	4	2	10
Cumberland	4	4	4	3	15
Daviess	0	0	2	1	3
Edmonson	2	2	6	3	13
Elliott	0	0	2	1	3
Estill	6	6	4	3	19
Fayette	6	6	4	3	19
Fleming	6	6	4	3	19
Floyd	4	4	4	3	15
Franklin	6	6	4	3	19
Fulton	2	2	4	2	10
Gallatin	2	2	4	3	11
Garrard	4	4	4	2	14
Grant	2	2	4	3	11
Graves	2	2	4	2	10
Grayson	2	2	0	1	5
Green	2	2	6	3	13
Greenup	0	0	2	1	3
Hancock	0	0	2	1	3
Hardin	4	4	2	3	13
Harlan	2	2	2	2	8
Harrison	6	6	2	3	17
Hart	4	4	4	3	15
Henderson	0	0	2	1	3
Henry	6	6	2	3	17
Hickman	2	2	4	2	10
Hopkins	0	0	4	2	6
Jackson	4	4	4	3	15
Jefferson	6	6	2	3	17
Jessamine	6	6	4	3	19
Johnson	4	4	4	3	15
Kenton	2	2	4	3	11
Knott	4	4	2	2	12
Knox	4	4	4	3	15
Larue	4	4	2	3	13
Laurel	4	4	4	3	15
Lawrence	0	0	2	1	3
Lee	4	4	4	3	15
Leslie	4	4	4	3	15
Letcher	2	2	4	3	11
Lewis	2	2	2	2	8
Lincoln	4	4	2	2	12
Livingston	2	2	4	2	10
Logan	2	2	6	3	13
Lyon	2	2	4	2	10
Madison	6	6	4	3	19
Magoffin	4	4	4	3	15
Marion	4	4	6	3	17
Marshall	2	2	4	2	10
Martin	4	4	4	3	15
Mason	2	2	2	2	8
McCracken	2	2	4	2	10
McCreary	4	4	4	3	15
McLean	0	0	2	1	3
Meade	6	6	2	3	17
Menifee	6	6	4	3	19
Mercer	4	4	6	3	17
Metcalfe	2	2	6	3	13
Monroe	2	2	6	3	13
Montgomery	6	6	4	3	19
Morgan	2	2	2	2	8
Muhlenburg	0	0	6	3	9
Nelson	6	6	2	3	17
Nicholas	6	6	4	3	19
Ohio	0	0	6	3	9
Oldham	6	6	2	3	17
Owen	6	6	4	3	19
Owsley	4	4	4	3	15
Pendleton	2	2	4	3	11
Perry	2	2	2	2	8
Pike	4	4	2	2	12
Powell	6	6	4	3	19
Pulaski	2	2	2	2	8
Robertson	4	4	4	3	15
Rockcastle	4	4	2	2	12
Rowan	2	2	4	3	11
Russell	2	2	2	2	8
Scott	6	6	4	3	19
Shelby	6	6	2	3	17
Simpson	2	2	4	2	10
Spencer	6	6	2	3	17
Taylor	0	0	6	3	9
Todd	0	0	2	1	3
Trigg	0	0	2	1	3
Trimble	6	6	2	3	17
Union	0	0	2	1	3
Warren	2	2	6	3	13
Washington	6	6	4	3	19
Wayne	2	2	2	2	8
Webster	0	0	4	2	6
Whitley	4	4	4	3	15
Wolfe	4	4	4	3	15
Woodford	6	6	4	3	19

2003 Commonwealth Group Plan Choices By County

County	HMO	POS	PPO	EPO	Total
Adair	4	4	4	2	14
Allen	2	2	2	1	7
Anderson	4	4	4	2	14
Ballard	2	2	2	1	7
Barren	0	0	2	1	3
Bath	4	4	4	2	14
Bell	4	4	4	2	14
Boone	2	2	4	2	10
Bourbon	6	6	6	3	21
Boyd	0	0	2	1	3
Boyle	2	2	2	1	7
Bracken	2	2	4	2	10
Breathitt	4	4	6	3	17
Breckinridge	2	2	2	1	7
Bullitt	2	2	2	1	7
Butler	2	2	2	1	7
Caldwell	2	2	2	1	7
Calloway	2	2	2	1	7
Campbell	2	2	4	2	10
Carlisle	2	2	2	1	7
Carroll	2	2	2	1	7
Carter	0	0	2	1	3
Casey	4	4	4	2	14
Christian	0	0	4	2	6
Clark	6	6	6	3	21
Clay	4	4	4	2	14
Clinton	2	2	4	2	10
Crittenden	2	2	2	1	7
Cumberland	4	4	6	3	17
Daviess	0	0	2	1	3
Edmonson	2	2	2	1	7
Elliott	0	0	2	1	3
Estill	6	6	6	3	21
Fayette	6	6	6	3	21
Fleming	2	2	2	1	7
Floyd	4	4	4	2	14
Franklin	6	6	6	3	21
Fulton	2	2	2	1	7
Gallatin	2	2	4	2	10
Garrard	4	4	4	2	14
Grant	2	2	4	2	10
Graves	2	2	2	1	7
Grayson	2	2	2	1	7
Green	2	2	2	2	8
Greenup	0	0	2	1	3
Hancock	0	0	2	1	3
Hardin	0	0	2	1	3
Harlan	2	2	4	2	10
Harrison	2	2	2	1	7
Hart	2	2	2	2	8
Henderson	0	0	2	1	3
Henry	4	4	4	2	14
Hickman	2	2	2	1	7
Hopkins	0	0	4	2	6
Jackson	4	4	6	3	17
Jefferson	4	4	2	2	12
Jessamine	6	6	6	3	21
Johnson	4	4	4	2	14
Kenton	2	2	4	2	10
Knott	4	4	4	2	14

County	HMO	POS	PPO	EPO	Total
Knox	4	4	4	2	14
Larue	0	0	2	1	3
Laurel	4	4	6	3	17
Lawrence	0	0	2	1	3
Lee	4	4	6	3	17
Leslie	4	4	6	3	17
Letcher	2	2	4	2	10
Lewis	2	2	2	1	7
Lincoln	2	2	2	1	7
Livingston	2	2	2	1	7
Logan	2	2	4	2	10
Lyon	2	2	2	1	7
Madison	6	6	6	3	21
Magoffin	4	4	4	2	14
Marion	4	4	4	2	14
Marshall	2	2	2	1	7
Martin	4	4	6	3	17
Mason	2	2	2	1	7
McCracken	2	2	2	1	7
McCreary	4	4	6	3	17
McLean	0	0	2	1	3
Meade	2	2	2	1	7
Menifee	4	4	4	2	14
Mercer	4	4	4	2	14
Metcalfe	2	2	4	2	10
Monroe	2	2	2	1	7
Montgomery	6	6	6	3	21
Morgan	2	2	2	1	7
Muhlenburg	0	0	6	3	9
Nelson	2	2	2	1	7
Nicholas	6	6	6	3	21
Ohio	0	0	4	2	6
Oldham	4	4	4	2	14
Owen	4	4	4	2	14
Owsley	2	2	2	1	7
Pendleton	2	2	4	2	10
Perry	2	2	4	2	10
Pike	4	4	4	2	14
Powell	2	2	2	1	7
Pulaski	2	2	2	1	7
Robertson	4	4	4	2	14
Rockcastle	2	2	2	1	7
Rowan	2	2	4	2	10
Russell	2	2	2	1	7
Scott	4	4	4	2	14
Shelby	2	2	2	1	7
Simpson	2	2	2	1	7
Spencer	2	2	2	1	7
Taylor	0	0	4	2	6
Todd	0	0	4	2	6
Trigg	0	0	2	1	3
Trimble	4	4	4	2	14
Union	0	0	2	1	3
Warren	2	2	4	2	10
Washington	4	4	4	2	14
Wayne	2	2	4	2	10
Webster	0	0	4	2	6
Whitley	4	4	6	3	17
Wolfe	4	4	6	3	17
Woodford	4	4	4	2	14

2002 Public Employee Health Insurance Program Benefit Provisions

HMO Plans		Option A	Option B
Annual Deductible		None	None
Maximum out-of-pocket for Covered Expenses	Co-insurance amounts for dental, vision, audiometric, and autism respite services do not apply to the out-of-pocket limits. Co-payments for prescription drugs do not apply to the out-of-pocket limits. All other co-payments and co-insurance amounts do apply.	Single: $1,000 Family: $2,000	Single: $1,500 Family: $3,000
Lifetime Maximum Benefit		Unlimited	Unlimited
In Hospital Care	Provider services, inpatient care, semi-private room, transplant coverage (kidney, cornea, bone marrow, heart, liver, lung, heart/lung, and pancreas), mental health and chemical dependency services. (Co-pays are per admission.)	$100 co-pay	$250 co-pay
Outpatient Services	Physician or Mental Health Provider Office (per visit) – visit, diagnostic and allergy testing, allergy serum and injections, diabetes education and therapy, well childcare, immunizations, injections, lab fees, x-rays, and mental health/chemical dependency services. Annual gynecological exam, routine physical, and certain early detection tests (age and periodicity limits may apply). All services performed on the same day (same site) are subject to one co-pay.	$10 co-pay	$20 co-pay
	Diagnostic Testing (per visit)-laboratory, x-ray and other radiology/imaging services, ultrasound and approved machine testing services performed for the purpose of diagnosing an illness or injury. All services performed on the same day (same site) are subject to one co-pay. Services received in a physician's office in conjunction with an office visit are only subject to the physician office visit co-pay; a separate diagnostic testing co-pay will not apply.	$10 co-pay	$20 co-pay
	Ambulatory Hospital and Outpatient Surgery (per visit) - outpatient surgery services (including biopsies), radiation therapy, renal dialysis, chemotherapy and other outpatient services not listed under diagnostic testing performed in a hospital or other ambulatory center (other than a physician's office).	$50 co-pay	$125 co-pay
Emergency Services	Hospital Emergency Room (per visit) – Co-pay is waived if admitted and in-hospital co-pay applies. Emergency physician covered in full.	$50 co-pay	$50 co-pay
	Urgent Care Center (not hospital emergency room) (per visit)	$20 co-pay	$30 co-pay
	Ambulance (per use)	20% co-insurance	25% co-insurance
Maternity Care	Prenatal, labor, delivery, postpartum care, and one ultrasound per pregnancy. More than one ultrasound per pregnancy is only covered with prior Plan approval. Office visit co-pay only applies to visit in which pregnancy is diagnosed	$10 co-pay Hospital in-patient co-pay also applies.	$20 co-pay Hospital in-patient co-pay also applies.
Prescription Drugs	Co-pay applies to each 1-month supply. Preauthorization may be required for certain drugs. Drugs are not available for non-covered services.	$10 generic $15 brand $30 non-formulary	$10 generic $15 brand $30 non-formulary
Dental	Preventive dental only. Limited to two oral exams and two routine cleanings per person, per plan year; one set of bitewing x-rays per person per plan year.	50% co-insurance; $100 maximum benefit per plan year.	Not covered
Vision	One routine eye exam visit per plan year for persons under 18. One routine eye exam every other year for persons 18 and older.	50% co-insurance; $75 maximum benefit per plan year.	Not covered
Other Services	Audiometric – Only covered in conjunction with a disease, illness, or injury.	50% co-insurance	Not covered
	Chiropractor (per visit) – No referral is necessary. Limit of 26 visits per year with no more than one visit per day.	$10 co-pay	$20 co-pay
	Durable Medical Equipment (DME) and Prosthetic Devices	20% co-insurance	25% co-insurance
	Home Health	20% co-insurance; Limit 60 visits per year.	25% co-insurance; Limit 40 visits per year.
	Hospice – Certain limits apply. Must be precertified by Plan.	Covered same as Medicare benefit.	Covered same as Medicare benefit.
	Autism Respite Services-$500 maximum monthly benefit. For children 2 to 21 years of age for respite and rehabilitative care.	50% co-insurance	50% co-insurance
	Physical Therapy (per visit) – Limit 30 visits per year.	$10 co-pay	$20 co-pay
	Occupational Therapy (per visit) – Limit 30 visits per year.	$10 co-pay	$20 co-pay
	Cardiac Rehabilitation Therapy (per visit) – Limit 30 visits per year.	$10 co-pay	$20 co-pay
	Speech Therapy (per visit) – Limit 30 visits per year.	$10 co-pay	$20 co-pay
	Skilled Nursing Facility (per admission) – Limit 30 days per year.	$100 co-pay	$250 co-pay

Referrals and/or prior approval may be required for some services. Please contact your Carrier.

2002 Public Employee Health Insurance Program Benefit Provisions

POS Plans		Option A		Option B	
		In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible		None	Single: $500 Family: $1,000	None	Single: $1,000 Family: $2,000
Maximum Out-of-Pocket for Covered Expenses (including deductible)	Co-insurance amounts for dental, vision, audiometric, and autism respite services do not apply to the out-of-pocket limits. Co-payments and co-insurance for prescription drugs do not apply to the out-of-pocket limits. All other co-payments and co-insurance amounts do apply.	Single: $1,000 Family: $2,000	Single: $2,500 Family: $5,000	Single: $1,500 Family: $3,000	Single: $4,000 Family: $8,000
Lifetime Maximum Benefit		Unlimited	Unlimited	Unlimited	Unlimited
In Hospital Care	Provider services, inpatient care, semi-private room, transplant coverage (kidney, cornea, bone marrow, heart, liver, lung, heart/lung, and pancreas), mental health and chemical dependency services.	$100 co-pay (per admission)	40% co-ins*	$250 co-pay (per admission)	50% co-ins*
Outpatient Services	Physician or Mental Health Provider Office (per visit), visit, diagnostic and allergy testing, allergy serum and injections, diabetes education and therapy, well childcare, immunizations, injections, lab fees, and x-rays, and mental health/chemical dependency services. Annual gynecological exam, routine physical, and certain early detection tests (age and periodicity limits may apply). All services performed on the same day (same site) are subject to one co-pay.	$10 co-pay (per visit)	40% co-ins*	$20 co-pay (per visit)	50% co-ins*
	Diagnostic Testing (per visit)-laboratory, x-ray and other radiology/imaging services, ultrasound and approved machine testing services performed for the purpose of diagnosing an illness or injury. All services performed on the same day (same site) are subject to one co-pay. Services received in a physician's office in conjunction with an office visit are only subject to the physician office visit co-pay; a separate diagnostic testing co-pay will not apply.	$10 co-pay (per visit)	40% co-ins*	$20 co-pay (per visit)	50% co-ins*
	Ambulatory Hospital and Outpatient Surgery (per visit) - outpatient surgery services (including biopsies), radiation therapy, renal dialysis, chemotherapy and other outpatient services not listed under diagnostic testing performed in a hospital or other ambulatory center (other than a physician's office).	$50 co-pay (per visit)	40% co-ins*	$125 co-pay (per visit)	50% co-ins*
Emergency Services	Hospital Emergency Room – $50 co-pay per visit is waived if admitted. In-hospital co-insurance applies.	$50 co-pay (per visit)	$50 co-pay plus 40% co-ins	$50 co-pay (per visit)	$50 co-pay plus 50% co-ins
	Emergency Room Physician	Covered in full	40% co-ins	Covered in full	50% co-ins
	Urgent Care Center (not hospital emergency room)	$20 co-pay (per visit)	40% co-ins*	$30 co-pay (per visit)	50% co-ins*
	Ambulance (per use)	20% co-ins	20% co-ins*	25% co-ins	25% co-ins*
Maternity Care	Prenatal, labor, delivery, postpartum care, and one ultrasound per pregnancy. More than one ultrasound per pregnancy is only covered with prior Plan approval. Office visit co-pay only applies to visit in which pregnancy is diagnosed	$10 co-pay Hospital in-patient co-pay also applies.	40% co-ins* Hospital in-patient co-ins* also applies.	$20 co-pay Hospital in-patient co-pay also applies.	50% co-ins* Hospital in-patient co-ins* also applies.
Prescription Drugs	Co-pay applies to each 1-month supply. Preauthorization may be required for certain drugs. Drugs are not available for non-covered services.	$10 generic $15 brand $30 non-formulary	40% co-ins*	$10 generic $15 brand $30 non-formulary	50% co-ins*
Dental	Preventive dental only. Limited to two oral exams and two routine cleanings per person per plan year. One set of bitewing x-rays per person per plan year.	50% co-ins $100 maximum benefit per year		Not covered	
Vision	One routine eye exam visit per plan year for persons under 18. One routine eye exam every other year for persons 18 and older.	50% co-ins $75 maximum benefit per year		Not covered	
Other Services	Audiometric – Only covered in conjunction with a disease, illness,or injury.	50% co-ins		Not covered	
	Chiropractor (per visit) – No referral is necessary. Limit of 26 visits per year with no more than one visit per day.	$10 co-pay (per visit)	40% co-ins*	$20 co-pay (per visit)	50% co-ins*
	Durable Medical Equipment (DME) and Prosthetic Devices	20% co-ins	40% co-ins*	25% co-ins	50% co-ins*
	Home Health	20% co-ins Limit 60 visits per year.	40% co-ins*	25% co-ins Limit 40 visits per year.	50% co-ins*
	Autism Respite Services-$500 maximum monthly benefit. For children 2 to 21 years of age for respite and rehabilitative care.	50% co-insurance	50% co-insurance*	50% co-insurance	50% co-insurance*
	Hospice – Certain limits apply. Must be precertified by Plan.	Covered same as Medicare benefit	Covered same as Medicare benefit	Covered same as Medicare benefit	Covered same as Medicare benefit
	Physical Therapy (per visit) – Limit 30 visits per year.	$10 co-pay	40% co-ins*	$20 co-pay	50% co-ins*
	Occupational Therapy (per visit) – Limit 30 visits per year.	$10 co-pay	40% co-ins*	$20 co-pay	50% co-ins*
	Cardiac Rehabilitation Therapy (per visit) – Limit 30 visits per year.	$10 co-pay	40% co-ins*	$20 co-pay	50% co-ins*
	Speech Therapy (per visit) – Limit 30 visits per year.	$10 co-pay	40% co-ins*	$20 co-pay	50% co-ins*
	Skilled Nursing Facility (per admission) – Limit 30 days per year.	$100 co-pay	40% co-ins*	$250 co-pay	50% co-ins*

2002 Public Employee Health Insurance Program Benefit Provisions

PPO Plans		Option A		Option B	
		In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible		Single: $250 Family: $500	Single: $500 Family: $1,000	Single: $500 Family: $1,000	Single: $1,000 Family: $2,000
Maximum out-of-pocket for Covered Expenses (including deductible)	Co-payments for office visits, hospital emergency room visits, urgent care center visits and coinsurance amounts for dental, vision, audiometric and autism respite services do not apply to the out-of-pocket limits. Co-payments and co-insurance for prescription drugs do not apply to the out-of-pocket limits.	Single: $1,250 Family: $2,500	Single: $2,500 Family: $5,000	Single: $2,000 Family: $4,000	Single: $4,000 Family: $8,000
Lifetime Maximum Benefit		Unlimited	Unlimited	Unlimited	Unlimited
In Hospital Care	Provider services, inpatient care, semi-private room, transplant coverage (kidney, cornea, bone marrow, heart, liver, lung, heart/lung, and pancreas), mental health and chemical dependency services.	20% co-ins*	40% co-ins*	25% co-ins*	50% co-ins*
Outpatient Services	Physician or Mental Health Provider Office (per visit)- visit, diagnostic and allergy testing, allergy serum and injections, diabetes education and therapy, well childcare, immunizations, injections, lab fees, x-rays, and mental health/chemical dependency services. All services performed on the same day (same site) are subject to one co-pay.	$10 co-pay (per visit)	40% co-ins*	25% co-ins*	50% co-ins*
	Annual gynecological exam, routine physical, and certain early detection tests. Age and periodicity limits may apply.	$10 co-pay (per visit) $400 maximum benefit per year	40% co-ins*	$20 co-pay (per visit) $300 maximum benefit per year	50% co-ins*
	Diagnostic Testing (per visit)- laboratory, x-ray and other radiology/imaging services, ultrasound and approved machine testing services performed for the purpose of diagnosing an illness or injury. All services performed on the same day (same site) are subject to one co-pay. Services received in a physician's office in conjunction with an office visit are only subject to the physician office visit co-pay; a separate diagnostic testing co-pay will not apply.	$10 co-pay (per visit)	40% co-ins*	25% co-ins*	50% co-ins*
	Ambulatory Hospital and Outpatient Surgery (per visit) – outpatient surgery services (including biopsies), radiation therapy, renal dialysis, chemotherapy, and other outpatient services not listed under diagnostic testing performed in a hospital or other ambulatory center (other than a physician's office).	20% co-ins*	40% co-ins*	25% co-ins*	50% co-ins*
Emergency Services	Hospital Emergency Room – $50 co-pay per visit is waived if admitted. In-hospital co-insurance applies.	$50 co-pay plus 20% co-ins	$50 co-pay plus 40% co-ins	$50 co-pay plus 25% co-ins	$50 co-pay plus 50% co-ins
	Emergency Room Physician	20% co-ins	40% co-ins	25% co-ins	50% co-ins
	Urgent Care Center (not hospital emergency room)	$20 co-pay (per visit)	40% co-ins*	$30 co-pay (per visit)	50% co-ins*
	Ambulance (per use)	20% co-ins*	20% co-ins*	25% co-ins*	25% co-ins*
Maternity Care	Prenatal, labor, delivery, postpartum care, and one ultrasound per pregnancy. More than one ultrasound per pregnancy is only covered with prior Plan approval. Office visit co-pay only applies to visit in which pregnancy is diagnosed.	$10 co-pay Hospital in-patient co-ins also applies.*	40% co-ins*	25% co-ins* Hospital in-patient co-ins also applies.*	50% co-ins*
Prescription Drugs	Co-pay applies to each 1-month supply. Preauthorization may be required for certain drugs. Drugs are not available for non-covered services.	$10 generic $15 brand $30 non-formulary	40% co-ins*	$10 generic $15 brand $30 non-formulary	50% co-ins*
Dental	Preventive dental only. Limited to two oral exams and two routine cleanings per person per plan year. One set of bitewing x-rays per person per plan year.	50% co-ins* $100 maximum benefit per year		Not covered	
Vision	One routine eye exam visit per plan year for persons under 18. One routine eye exam every other year for persons 18 and older.	50% co-ins* $75 maximum benefit per year		Not covered	
Other Services	Audiometric – Only covered in conjunction with a disease, illness or injury.	50% co-ins*		Not covered	
	Chiropractor (per visit) – No referral is necessary. Limit of 26 visits per year with no more than one visit per day.	$10 co-pay (per visit)	40% co-ins*	25% co-ins*	50% co-ins*
	Durable Medical Equipment (DME) and Prosthetic Devices	20% co-ins*	40% co-ins*	25% co-ins*	50% co-ins*
	Home Health	20% co-ins* Limit 60 visits per year.	40% co-ins*	25% co-ins* Limit 40 visits per year.	50% co-ins*
	Autism Respite Services – $500 maximum monthly benefit. For children 2 to 21 years of age for respite and rehabilitative care.	50% co-ins*	50% co-ins*	50% co-ins*	50% co-ins*
	Hospice – Certain limits apply. Must be precertified by Plan.	Covered same as Medicare benefit	Covered same as Medicare benefit	Covered same as Medicare benefit	Covered same as Medicare benefit
	Physical Therapy (per visit) – Limit 30 visits per year.	20% co-ins*	40% co-ins*	25% co-ins*	50% co-ins*
	Occupational Therapy (per visit) – Limit 30 visits per year.	20% co-ins*	40% co-ins*	25% co-ins*	50% co-ins*
	Cardiac Rehabilitation Therapy (per visit) – Limit 30 visits per year.	20% co-ins*	40% co-ins*	25% co-ins*	50% co-ins*
	Speech Therapy (per visit) – Limit 30 visits per year.	20% co-ins*	40% co-ins*	25% co-ins*	50% co-ins*
	Skilled Nursing Facility (per visit) – Limit 30 days per year.	20% co-ins*	40% co-ins*	25% co-ins*	50% co-ins*

2002 Public Employee Health Insurance Program Benefit Provisions

Exclusive Provider Option		Option C
Annual Deductible		None
Maximum out-of-pocket for Covered Expenses	Coinsurance amounts for autism respite services do not apply to the out-of-pocket limits. Co-payments for prescription drugs do not apply to the out-of-pocket limits. All other co-payments and co-insurance amounts do apply.	Single: $4,000 Family: $8,000
Lifetime Maximum Benefit		Unlimited
In Hospital Care	Provider services, inpatient care, semi-private room, transplant coverage (kidney, cornea, bone marrow, heart, liver, lung, heart/lung, and pancreas), mental health and chemical dependency services. (Co-pays are per admission.)	$1,500 co-pay (per admission)
Outpatient Services	Physician or Mental Health Provider Office (per visit) – visit, diagnostic and allergy testing, allergy serum and injections, diabetes education and therapy, well childcare, injections, lab fees, x-rays and mental health and chemical dependency services. Annual gynecological exam and associated Pap test. Adult physical exam – visit only – see Preventive Testing below. All services performed on the same day (same site) are subject to one co-pay.	$25 co-pay (per visit)
	Ambulatory Hospital and Outpatient Surgery (per visit) – outpatient surgery services (including biopsies), radiation therapy, renal dialysis, chemotherapy and other outpatient services not listed under diagnostic testing performed in a hospital or other ambulatory center (other than a physician's office).	$500 co-pay (per visit)
	Diagnostic Testing (per visit) – laboratory, x-ray and other radiology/imaging services, ultrasound and approved machine testing services performed for the purpose of diagnosing an illness or injury. All services performed on the same day (same site) are subject to one co-pay. Services received in a physician's office in conjunction with an office visit are only subject to the physician office visit co-pay; a separate diagnostic testing co-pay will not apply.	$25 co-pay (per visit)
	Preventive Testing* – Covered at Health Departments. Mammograms, cholesterol screenings, glucose serum testing, and PSA.	50% co-insurance
	Immunizations* – All early childhood immunizations; flu, pneumonia, and tetanus vaccinations for adults.	50% co-insurance
Emergency Services	Hospital Emergency Room (per visit) – Co-pay is waived if admitted and in-hospital co-pay applies. Emergency physician covered in full.	$75 co-pay (per visit)
	Urgent Care Center (not hospital emergency room) (per visit)	$50 co-pay (per visit)
	Ambulance (per use)	$75 co-pay (per visit)
Maternity Care	Prenatal, labor, delivery, postpartum care, and one ultrasound per pregnancy. More than one ultrasound per pregnancy is only covered with prior Plan approval.	$25 co-pay (per visit) Hospital in-patient co-pay also applies.
Prescription Drugs	Copay applies to each 1-month supply. Preauthorization may be required for certain drugs. Drugs are not covered for non-covered services.	$25 generic $35 brand $50 non-formulary
Dental		Not covered
Vision		Not covered
Other Services	Audiometric	Not covered
	Chiropractor (per visit) – No referral is necessary. Limit of 15 visits per year. No more than one visit per day.	50% co-insurance Limit 15 visits per year.
	Durable Medical Equipment (DME) and Prosthetic Devices	50% coinsurance
	Home Health	Covered in full. Limit 20 visits per year.
	Autism Respite Services – $500 maximum monthly benefit for children 2 - 21 years of age for respite and rehabilitative care.	50% co-insurance
	Hospice – Certain limits apply. Must be precertified by Plan.	Covered same as Medicare benefit.
	Physical Therapy (per visit) – Limit 20 visits per year.	$30 co-pay (per visit)
	Occupational Therapy (per visit) – Limit 20 visits per year.	$30 co-pay (per visit)
	Cardiac Rehabilitation Therapy (per visit) – Limit 20 visits per year.	$30 co-pay (per visit)
	Speech Therapy (per visit) – Limit 20 visits per year.	$30 co-pay (per visit)
	Skilled Nursing Facility (per admission) – Limit 20 days per year.	$1,500 co-pay

2003 Public Employee Health Insurance Program Benefit Provisions

HMO Plans		Option A	Option B
Annual Deductible		None	None
Maximum out-of-pocket for Covered Expenses	Co-payments for prescription drugs do not apply to the out-of-pocket limits. All other co-payments and co-insurance amounts do apply.	Single: $1,000 Family: $2,000	Single: $1,500 Family: $3,000
Lifetime Maximum Benefit		Unlimited	Unlimited
In Hospital Care	Provider services, inpatient care, semi-private room, transplant coverage (kidney, cornea, bone marrow, heart, liver, lung, heart/lung, and pancreas), mental health and chemical dependency services. (Co-pays are per admission.)	$100 co-pay	$250 co-pay
Outpatient Services	Physician or Mental Health Provider Office (per visit) – visit, diagnostic and allergy testing, allergy serum and injections, diabetes education and therapy, well childcare, immunizations, injections, lab fees, x-rays, and mental health/chemical dependency services. Annual gynecological exam, routine physical, and certain early detection tests (age and periodicity limits may apply). All services performed on the same day (same site) are subject to one co-pay.	$10 co-pay	$20 co-pay
	Diagnostic Testing (per visit)-laboratory, x-ray and other radiology/imaging services, ultrasound and approved machine testing services performed for the purpose of diagnosing an illness or injury. All services performed on the same day (same site) are subject to one co-pay. Services received in a physician's office in conjunction with an office visit are only subject to the physician office visit co-pay; a separate diagnostic testing co-pay will not apply.	$10 co-pay	$20 co-pay
	Ambulatory Hospital and Outpatient Surgery (per visit) - outpatient surgery services (including biopsies), radiation therapy, renal dialysis, chemotherapy and other outpatient services not listed under diagnostic testing performed in a hospital or other ambulatory center (other than a physician's office).	$50 co-pay	$125 co-pay
Emergency Services	Hospital Emergency Room (per visit) – Co-pay is waived if admitted and in-hospital co-pay applies. Emergency physician covered in full.	$50 co-pay	$50 co-pay
	Urgent Care Center (not hospital emergency room) (per visit)	$20 co-pay	$30 co-pay
	Ambulance (per use)	20% co-insurance	25% co-insurance
Maternity Care	Prenatal, labor, delivery, postpartum care, and one ultrasound per pregnancy. More than one ultrasound per pregnancy is only covered with prior Plan approval. Office visit co-pay only applies to visit in which pregnancy is diagnosed	$10 co-pay Hospital in-patient co-pay also applies.	$20 co-pay Hospital in-patient co-pay also applies.
Prescription Drugs **Retail**	Co-pay applies to each 1-month (30-day) supply. Preauthorization may be required for certain drugs. Drugs are not available for non-covered services.	$10 generic $15 brand $30 non-formulary	$10 generic $15 brand $30 non-formulary
Mail Order	Co-pay applies to each 3-month (90-day) supply of maintenance drugs only. Preauthorization may be required for certain drugs. Drugs are not available for non-covered services.	$20 generic $30 brand $60 non-formulary	$20 generic $30 brand $60 non-formulary
Dental		Not Covered	Not covered
Vision		Not Covered	Not covered
Other Services	Audiometric – Only covered in conjunction with a disease, illness, or injury.	50% co-insurance	Not covered
	Chiropractor (per visit) – No referral is necessary. Limit of 26 visits per year with no more than one visit per day.	$10 co-pay	$20 co-pay
	Durable Medical Equipment (DME) and Prosthetic Devices	20% co-insurance	25% co-insurance
	Hearing Aids (Under 18 years of age. One per ear every three years, $1,400 maximum per ear.)	20% co-insurance	25% co-insurance
	Home Health	20% co-insurance; Limit 60 visits per year.	25% co-insurance; Limit 40 visits per year.
	Hospice – Certain limits apply. Must be precertified by Plan.	Covered same as Medicare benefit.	Covered same as Medicare benefit.
	Autism Services-$500 maximum monthly benefit. For children 2 through 21 years of age • Rehabilitative and Therapeutic care • Respite Care	 $10 co-pay 50% co-insurance	 $20 co-pay 50% co-insurance
	Physical Therapy (per visit) – Limit 30 visits per year.	$10 co-pay	$20 co-pay
	Occupational Therapy (per visit) – Limit 30 visits per year.	$10 co-pay	$20 co-pay
	Cardiac Rehabilitation Therapy (per visit) – Limit 30 visits per year.	$10 co-pay	$20 co-pay
	Speech Therapy (per visit) – Limit 30 visits per year.	$10 co-pay	$20 co-pay
	Skilled Nursing Facility (per admission) – Limit 30 days per year.	$100 co-pay	$250 co-pay

Referrals and/or prior approval may be required for some services. Please contact your Carrier.

2003 Public Employee Health Insurance Program Benefit Provisions

POS Plans		Option A		Option B	
		In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible		None	Single: $500 Family: $1,000	None	Single: $1,000 Family: $2,000
Maximum Out-of-Pocket for Covered Expenses (including deductible)	Co-payments and co-insurance for prescription drugs do not apply to the out-of-pocket limits. All other co-payments and co-insurance amounts do apply.	Single: $1,000 Family: $2,000	Single: $2,500 Family: $5,000	Single: $1,500 Family: $3,000	Single: $4,000 Family: $8,000
Lifetime Maximum Benefit		Unlimited	Unlimited	Unlimited	Unlimited
In Hospital Care	Provider services, inpatient care, semi-private room, transplant coverage (kidney, cornea, bone marrow, heart, liver, lung, heart/lung, and pancreas), mental health and chemical dependency services.	$100 co-pay (per admission)	40% co-ins*	$250 co-pay (per admission)	50% co-ins*
Outpatient Services	Physician or Mental Health Provider Office (per visit), visit, diagnostic and allergy testing, allergy serum and injections, diabetes education and therapy, well childcare, immunizations, injections, lab fees, and x-rays, and mental health/chemical dependency services. Annual gynecological exam, routine physical, and certain early detection tests (age and periodicity limits may apply). All services performed on the same day (same site) are subject to one co-pay.	$10 co-pay (per visit)	40% co-ins*	$20 co-pay (per visit)	50% co-ins*
	Diagnostic Testing (per visit)-laboratory, x-ray and other radiology/imaging services, ultrasound and approved machine testing services performed for the purpose of diagnosing an illness or injury. All services performed on the same day (same site) are subject to one co-pay. Services received in a physician's office in conjunction with an office visit are only subject to the physician office visit co-pay; a separate diagnostic testing co-pay will not apply.	$10 co-pay (per visit)	40% co-ins*	$20 co-pay (per visit)	50% co-ins*
	Ambulatory Hospital and Outpatient Surgery (per visit) - outpatient surgery services (including biopsies), radiation therapy, renal dialysis, chemotherapy and other outpatient services not listed under diagnostic testing performed in a hospital or other ambulatory center (other than a physician's office).	$50 co-pay (per visit)	40% co-ins*	$125 co-pay (per visit)	50% co-ins*
Emergency Services	Hospital Emergency Room – $50 co-pay per visit is waived if admitted. In-hospital co-insurance applies.	$50 co-pay (per visit)	$50 co-pay plus 40% co-ins	$50 co-pay (per visit)	$50 co-pay plus 50% co-ins
	Emergency Room Physician	Covered in full	40% co-ins	Covered in full	50% co-ins
	Urgent Care Center (not hospital emergency room)	$20 co-pay (per visit)	40% co-ins*	$30 co-pay (per visit)	50% co-ins*
	Ambulance (per use)	20% co-ins	20% co-ins*	25% co-ins	25% co-ins*
Maternity Care	Prenatal, labor, delivery, postpartum care, and one ultrasound per pregnancy. More than one ultrasound per pregnancy is only covered with prior Plan approval. Office visit co-pay only applies to visit in which pregnancy is diagnosed	$10 co-pay Hospital in-patient co-pay also applies.	40% co-ins* Hospital in-patient co-ins* also applies.	$20 co-pay Hospital in-patient co-pay also applies.	50% co-ins* Hospital in-patient co-ins* also applies.
Prescription Drugs Retail	Co-pay applies to each 1-month (30-day) supply. Preauthorization may be required for certain drugs. Drugs are not available for non-covered services.	$10 generic $15 brand $30 non-formulary	40% co-ins*	$10 generic $15 brand $30 non-formulary	50% co-ins*
Mail Order	Co-pay applies to each 3-month (90-day) supply of maintenance drugs only. Preauthorization may be required for certain drugs. Drugs are not available for non-covered services.	$20 generic $30 brand $60 non-formulary		$20 generic $30 brand $60 non-formulary	
Dental		Not Covered		Not covered	
Vision		Not Covered		Not covered	
Other Services	Audiometric – Only covered in conjunction with a disease, illness, or injury.	50% co-ins		Not covered	
	Chiropractor (per visit) – No referral is necessary. Limit of 26 visits per year with no more than one visit per day.	$10 co-pay (per visit)	40% co-ins*	$20 co-pay (per visit)	50% co-ins*
	Durable Medical Equipment (DME) and Prosthetic Devices	20% co-ins	40% co-ins*	25% co-ins	50% co-ins*
	Hearing Aids (Under 18 years of age. One per ear every three years, $1,400 maximum per ear.)	20% co-ins	40% co-ins*	25% co-ins	50% co-ins*
	Home Health	20% co-ins Limit 60 visits per year.	40% co-ins*	25% co-ins Limit 40 visits per year.	50% co-ins*
	Autism Services-$500 maximum monthly benefit. For children 2 through 21 years of age • Rehabilitative and Therapeutic care • Respite Care	 $10 co-pay 50% co-insurance	 40% co-ins* 50% co-insurance*	 $20 co-pay 50% co-insurance	 50% co-ins* 50% co-insurance*
	Hospice – Certain limits apply. Must be precertified by Plan.	Covered same as Medicare benefit	Covered same as Medicare benefit	Covered same as Medicare benefit	Covered same as Medicare benefit
	Physical Therapy (per visit) – Limit 30 visits per year.	$10 co-pay	40% co-ins*	$20 co-pay	50% co-ins*
	Occupational Therapy (per visit) – Limit 30 visits per year.	$10 co-pay	40% co-ins*	$20 co-pay	50% co-ins*
	Cardiac Rehabilitation Therapy (per visit) – Limit 30 visits per year.	$10 co-pay	40% co-ins*	$20 co-pay	50% co-ins*
	Speech Therapy (per visit) – Limit 30 visits per year.	$10 co-pay	40% co-ins*	$20 co-pay	50% co-ins*
	Skilled Nursing Facility (per admission) – Limit 30 days per year.	$100 co-pay	40% co-ins*	$250 co-pay	50% co-ins*

*Deductible applies. Once deductible is met, the member pays the percentage of co-insurance that is indicated for that service.
Note: Visit limits and/or dollar limits are applied on a combined basis when both in-network and out-of-network benefits are offered.
Referrals and/or prior approval may be required for some services. Please contact your Carrier.

2003 Public Employee Health Insurance Program Benefit Provisions

PPO Plans		Option A		Option B	
		In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible		Single: $250 Family: $500	Single: $500 Family: $1,000	Single: $500 Family: $1,000	Single: $1,000 Family: $2,000
Maximum out-of-pocket for Covered Expenses (including deductible)	Co-payments for office visits, hospital emergency room visits, urgent care center visits services do not apply to the out-of-pocket limits. Co-payments and co-insurance for prescription drugs do not apply to the out-of-pocket limits.	Single: $1,250 Family: $2,500	Single: $2,500 Family: $5,000	Single: $2,000 Family: $4,000	Single: $4,000 Family: $8,000
Lifetime Maximum Benefit		Unlimited	Unlimited	Unlimited	Unlimited
In Hospital Care	Provider services, inpatient care, semi-private room, transplant coverage (kidney, cornea, bone marrow, heart, liver, lung, heart/lung, and pancreas), mental health and chemical dependency services.	20% co-ins*	40% co-ins*	25% co-ins*	50% co-ins*
Outpatient Services	Physician or Mental Health Provider Office (per visit)- visit, diagnostic and allergy testing, allergy serum and injections, diabetes education and therapy, well childcare, immunizations, injections, lab fees, x-rays, and mental health/chemical dependency services. All services performed on the same day (same site) are subject to one co-pay.	$10 co-pay (per visit)	40% co-ins*	25% co-ins*	50% co-ins*
	Annual gynecological exam, routine physical, and certain early detection tests. Age and periodicity limits may apply.	$10 co-pay (per visit)	40% co-ins*	$20 co-pay (per visit)	50% co-ins*
		$400 maximum benefit per year		$300 maximum benefit per year	
	Diagnostic Testing (per visit)- laboratory, x-ray and other radiology/imaging services, ultrasound and approved machine testing services performed for the purpose of diagnosing an illness or injury. All services performed on the same day (same site) are subject to one co-pay. Services received in a physician's office in conjunction with an office visit are only subject to the physician office visit co-pay; a separate diagnostic testing co-pay will not apply.	$10 co-pay (per visit)	40% co-ins*	25% co-ins*	50% co-ins*
	Ambulatory Hospital and Outpatient Surgery (per visit) – outpatient surgery services (including biopsies), radiation therapy, renal dialysis, chemotherapy, and other outpatient services not listed under diagnostic testing performed in a hospital or other ambulatory center (other than a physician's office).	20% co-ins*	40% co-ins*	25% co-ins*	50% co-ins*
Emergency Services	Hospital Emergency Room – $50 co-pay per visit is waived if admitted. In-hospital co-insurance applies.	$50 co-pay plus 20% co-ins	$50 co-pay plus 40% co-ins	$50 co-pay plus 25% co-ins	$50 co-pay plus 50% co-ins
	Emergency Room Physician	20% co-ins	40% co-ins	25% co-ins	50% co-ins
	Urgent Care Center (not hospital emergency room)	$20 co-pay (per visit)	40% co-ins*	$30 co-pay (per visit)	50% co-ins*
	Ambulance (per use)	20% co-ins*	20% co-ins*	25% co-ins*	25% co-ins*
Maternity Care	Prenatal, labor, delivery, postpartum care, and one ultrasound per pregnancy. More than one ultrasound per pregnancy is only covered with prior Plan approval. Office visit co-pay only applies to visit in which pregnancy is diagnosed.	$10 co-pay Hospital in-patient co-ins also applies.*	40% co-ins*	25% co-ins* Hospital in-patient co-ins also applies.*	50% co-ins*
Prescription Drugs Retail	Co-pay applies to each 1-month (30-day) supply. Preauthorization may be required for certain drugs. Drugs are not available for non-covered services.	$10 generic $15 brand $30 non-formulary	40% co-ins*	$10 generic $15 brand $30 non-formulary	50% co-ins*
Mail Order	Co-pay applies to each 3-month (90-day) supply of maintenance drugs only. Preauthorization may be required for certain drugs. Drugs are not available for non-covered services.	$20 generic $30 brand $60 non-formulary		$20 generic $30 brand $60 non-formulary	
Dental		Not Covered		Not covered	
Vision		Not Covered		Not covered	
Other Services	Audiometric – Only covered in conjunction with a disease, illness or injury.	50% co-ins*		Not covered	
	Chiropractor (per visit) – No referral is necessary. Limit of 26 visits per year with no more than one visit per day.	$10 co-pay (per visit)	40% co-ins*	25% co-ins*	50% co-ins*
	Durable Medical Equipment (DME) and Prosthetic Devices	20% co-ins*	40% co-ins*	25% co-ins*	50% co-ins*
	Hearing Aids (Under 18 years of age. One per ear every three years, $1,400 maximum per ear.)	20% co-ins*	40% co-ins*	25% co-ins*	50% co-ins*
	Home Health	20% co-ins*	40% co-ins*	25% co-ins*	50% co-ins*
		Limit 60 visits per year.		Limit 40 visits per year.	
	Autism Services-$500 maximum monthly benefit. For children 2 through 21 years of age				
	• Rehabilitative and Therapeutic care	$10 co-pay	40% co-ins*	25% co-ins*	50% co-ins*
	• Respite Care	50% co-ins*	50% co-ins*	50% co-ins*	50% co-ins*
	Hospice – Certain limits apply. Must be precertified by Plan.	Covered same as Medicare benefit	Covered same as Medicare benefit	Covered same as Medicare benefit	Covered same as Medicare benefit
	Physical Therapy (per visit) – Limit 30 visits per year.	20% co-ins*	40% co-ins*	25% co-ins*	50% co-ins*
	Occupational Therapy (per visit) – Limit 30 visits per year.	20% co-ins*	40% co-ins*	25% co-ins*	50% co-ins*
	Cardiac Rehabilitation Therapy (per visit) – Limit 30 visits per year.	20% co-ins*	40% co-ins*	25% co-ins*	50% co-ins*
	Speech Therapy (per visit) – Limit 30 visits per year.	20% co-ins*	40% co-ins*	25% co-ins*	50% co-ins*
	Skilled Nursing Facility (per visit) – Limit 30 days per year.	20% co-ins*	40% co-ins*	25% co-ins*	50% co-ins*

*Deductible applies. Once deductible is met, the member pays the percentage of co-insurance that is indicated for that service.
Note: Visit limits and/or dollar limits are applied on a combined basis when both in-network and out-of-network benefits are offered.
Prior approval may be required for some services. Please contact your Carrier.

2003 Public Employee Health Insurance Program Benefit Provisions

EPO Plan		
Annual Deductible		None
Maximum out-of-pocket for Covered Expenses	Co-payments for prescription drugs do not apply to the out-of-pocket limits. All other co-payments and co-insurance amounts do apply.	Single: $4,000 Family: $8,000
Lifetime Maximum Benefit		Unlimited
In Hospital Care	Provider services, inpatient care, semi-private room, transplant coverage (kidney, cornea, bone marrow, heart, liver, lung, heart/lung, and pancreas), mental health and chemical dependency services. (Co-pays are per admission.)	$1,500 co-pay (per admission)
Outpatient Services	Physician or Mental Health Provider Office (per visit) – visit, diagnostic and allergy testing, allergy serum and injections, diabetes education and therapy, well childcare, injections, lab fees, x-rays and mental health and chemical dependency services. Annual gynecological exam and associated Pap test. Adult physical exam – visit only – see Preventive Testing below. All services performed on the same day (same site) are subject to one co-pay.	$25 co-pay (per visit)
	Ambulatory Hospital and Outpatient Surgery (per visit) – outpatient surgery services (including biopsies), radiation therapy, renal dialysis, chemotherapy and other outpatient services not listed under diagnostic testing performed in a hospital or other ambulatory center (other than a physician's office).	$500 co-pay (per visit)
	Diagnostic Testing (per visit) – laboratory, x-ray and other radiology/imaging services, ultrasound and approved machine testing services performed for the purpose of diagnosing an illness or injury. All services performed on the same day (same site) are subject to one co-pay. Services received in a physician's office in conjunction with an office visit are only subject to the physician office visit co-pay; a separate diagnostic testing co-pay will not apply.	$25 co-pay (per visit)
	Preventive Testing* – Covered at Health Departments. Mammograms, cholesterol screenings, glucose serum testing, and PSA.	50% co-insurance
	Immunizations* – All early childhood immunizations; flu, pneumonia, and tetanus vaccinations for adults.	50% co-insurance
Emergency Services	Hospital Emergency Room (per visit) – Co-pay is waived if admitted and in-hospital co-pay applies. Emergency physician covered in full.	$75 co-pay (per visit)
	Urgent Care Center (not hospital emergency room) (per visit)	$50 co-pay (per visit)
	Ambulance (per use)	$75 co-pay (per visit)
Maternity Care	Prenatal, labor, delivery, postpartum care, and one ultrasound per pregnancy. More than one ultrasound per pregnancy is only covered with prior Plan approval.	$25 co-pay (per visit) Hospital in-patient co-pay also applies.
Prescription Drugs **Retail**	Co-pay applies to each 1-month (30-day) supply. Preauthorization may be required for certain drugs. Drugs are not covered for non-covered services.	$25 generic $35 brand $50 non-formulary
Mail Order	Co-pay applies to each 3-month (90-day) supply of maintenance drugs only. Preauthorization may be required for certain drugs. Drugs are not available for non-covered services.	$50 generic $70 brand $100 non-formulary
Dental		Not covered
Vision		Not covered
Other Services	Audiometric	Not covered
	Chiropractor (per visit) – No referral is necessary. Limit of 15 visits per year. No more than one visit per day.	50% co-insurance Limit 15 visits per year.
	Durable Medical Equipment (DME) and Prosthetic Devices	50% coinsurance
	Hearing Aids (Under 18 years of age. One per ear every three years, $1,400 maximum per ear.)	50% coinsurance
	Home Health	Covered in full. Limit 20 visits per year.
	Autism Services-$500 maximum monthly benefit. For children 2 through 21 years of age • Rehabilitative and Therapeutic care • Respite Care	 $25 co-pay (per visit) 50% co-insurance
	Hospice – Certain limits apply. Must be precertified by Plan.	Covered same as Medicare benefit.
	Physical Therapy (per visit) – Limit 20 visits per year.	$30 co-pay (per visit)
	Occupational Therapy (per visit) – Limit 20 visits per year.	$30 co-pay (per visit)
	Cardiac Rehabilitation Therapy (per visit) – Limit 20 visits per year.	$30 co-pay (per visit)
	Speech Therapy (per visit) – Limit 20 visits per year.	$30 co-pay (per visit)
	Skilled Nursing Facility (per admission) – Limit 20 days per year.	$1,500 co-pay

*Health Departments shall be given the right of first refusal. Note: Only services from network providers are covered.

Referrals and/or prior approval may be required for some services. Please contact your Carrier.